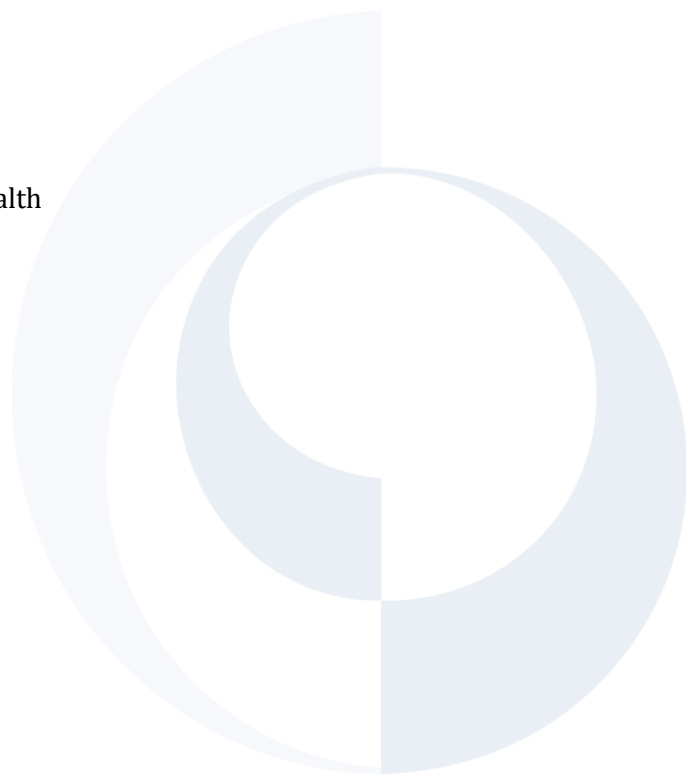


Scale-Up of the Standard Days Method® (SDM) in Rwanda

Submitted November 2013
The Institute for Reproductive Health
Georgetown University



USAID
FROM THE AMERICAN PEOPLE



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The Institute for Reproductive Health (IRH) is part of the Georgetown University Medical Center, an internationally recognized academic medical center with a three-part mission of research, teaching and patient care. IRH is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, fertility awareness-based methods (FAM) of family planning.

IRH was awarded the 5-year Fertility Awareness-Based Methods (FAM) Project by the United States Agency for International Development (USAID) in September 2007. This 5-year project aims to increase access and use of FAM within a broad range of service delivery programs using systems-oriented scaling up approaches.

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Acronyms

AFR	Action Familiale au Rwanda
ARBEF	Association Rwandaise pour le Bien Etre Familiale
BCC	Behavior Change Communication
CAMERWA	Central d'Achat des Médicaments Essentiels du Rwanda
CBD/P	Community-Based Distribution or Provision
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
FAM	Fertility Awareness-Based Methods
FP	Family Planning
FPTWG	Family Planning Technical Working Group
IEC	Information-Education-Communication
IRH	Institute for Reproductive Health
MCH	Maternal Child Health (Task Force)
MIS	Management Information System
MoH	Ministry of Health
PBF	Performance-Based Financing
PSI	Population Services International
UNFPA	United Nations Population Funds
USAID	United States Agency for International Development

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Executive Summary

Since the early 2000s, the Institute for Reproductive Health at Georgetown University (IRH) has introduced and tested the Standard Days Method® (SDM) in a variety of service delivery settings around the world. IRH and partners are now scaling up SDM services in family planning (FP) programs in the Democratic Republic of Congo, Guatemala, India, Mali, and Rwanda.

This report summarizes events in Rwanda, including choices, approaches and results of systematic SDM scale-up and related research. It concludes with an analysis of factors that influenced scale-up.

In 2002, when SDM was introduced in Rwanda, the Ministry of Health (MOH) and its donor partners (especially USAID) supported FP as an important component of the primary health care system’s revitalization. The government prioritized population issues—notably, slowing rapid population growth to increase economic and social stability—and backed a strong FP policy and program throughout the country. The sociocultural environment at the time exhibited somewhat contradictory influences: women expressed the desire to plan their pregnancies, yet people felt the need to have large families after the tremendous loss of life in 1994. The 2000 DHS measured unmet need for contraception at 36.4%.

The population of Rwanda is highly religious with up to 40% of health facilities managed or co-managed (with the MOH) by faith-based organizations (FBO). Most of these FBOs support the use of natural FP methods.

The challenge for the MOH and partners was to improve and extend FP services within this unique environment. Expanding the range of available options, and making them more attractive to potential users, was one way to do this. As a natural method with scientific evidence of its effectiveness, SDM had the potential to be a strong addition to the method mix in Rwanda.



Map: Adapted from www.gov.rw

RWANDA AT-A-GLANCE

CURRENT POPULATION:	10.9 million
POPULATION GROWTH RATE:	2.96% per year
GDP PER CAPITA, 2012:	\$582.5
TOTAL FERTILITY RATE:	5.34
CONTRACEPTIVE PREVALENCE, WOMEN AGES 15-49, 2009:	51.6%
UNMET NEED FOR CONTRACEPTION, MARRIED WOMEN AGES 15-49, 2010:	20.8%
MATERNAL MORTALITY RATIO PER 100,000 LIVE BIRTHS:	480
INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS:	38.1

Sources: World Bank World Development Indicators

HOW SUCCESSFUL WAS SCALE-UP OF SDM IN RWANDA?

As of December 2012:

SERVICE EXPANSION

SDM services available in 717 service delivery points and in all 30 districts of Rwanda (public, private)

Seven organizations including the MOH are able to build others' capacity to offer SDM

INSTITUTIONALIZATION

SDM fully integrated into national FP program and these sub-systems:

- Most norms, policies, guidelines
- MIS Reporting system
- Pre-service training curricula
- Logistics system
- National surveys
- MOH-sanctioned IEC materials

SDM USERS & KNOWLEDGE OF SDM OPTION

The majority of women (95%) and men (88%) had heard of SDM at endline.

SDM users comprised about 7.4% percent of all FP users. This is an indicator of successful scale-up, based on past IRH studies.

Of those who discontinued SDM, 100% cited their menstrual cycle was outside the eligibility range.

Introductory Phase 2002-2007

In 2002, USAID invited IRH to provide technical assistance to the MOH to introduce SDM in Rwanda. Using a research-to-practice approach, IRH and the MOH initially selected 13 sites within a USAID-funded health project to pilot SDM services. IRH built MOH capacity to train health workers to provide the method, and supervisors to oversee service quality. By the end of the introductory phase, SDM was available in 74 sites in Rwanda—about 20% of the country—and more than 800 providers were trained to offer the method. Several FBOs and NGOs had gained capacity to deliver SDM services, directly or via their support of MOH health facilities.

Because SDM was introduced while the MOH and donors were revitalizing Rwanda's overall FP program overall, IRH had opportunity to embed the method in policy, protocols and norms as they were being revised. By 2007, SDM was integrated into pre-service and in-service training curricula, the health information system, the logistics system, supervisory tools, national surveys, and information-education-communication (IEC) materials.

IRH research, done at several points during the introductory phase, detected solid evidence of demand for and satisfaction with SDM. More than 90% of users correctly identified their fertile days, and said they and their partners found it easy to manage the 12-day fertile window. Community health workers (CHW) were found to be competent SDM counselors. New SDM users represented five to 12% of all new FP users as early as 2004.

In short, SDM's attributes favored its scale-up in Rwanda: client satisfaction, male involvement, acceptance by churches and users whose religion discouraged the use of hormonal or barrier methods, and ease/appropriateness of service delivery in health facilities and in communities. The MOH, donors and FBOs supported the scale-up phase to increase access and availability, and to further institutionalize the method, in Rwanda.

Scale-Up Phase 2007-2012

The *five-year SDM scale-up phase* began in late 2007. In its ongoing role as scale-up catalyst, IRH used the ExpandNet framework to plan its multi-year strategy, to clarify with all stakeholders what successful scale-up meant and what would be required to achieve it, and to maintain appropriate balance along the vertical (institutionalization) and horizontal (geographic expansion) axes of SDM scale-up in Rwanda. During this phase, IRH's Country Representative was an active member of the MOH's Family Planning Technical Working Group (FP TWG), whose task was to ensure widespread access to a range of FP services and products, including SDM and CycleBeads®, throughout the country.

Using Data to Guide Scale-Up

Routine monitoring data, punctuated by several types of evaluation, helped IRH and the FP TWG track SDM scale-up, identify problems and design solutions, detect successes, and inform stakeholders about the contribution of SDM to the national FP program.

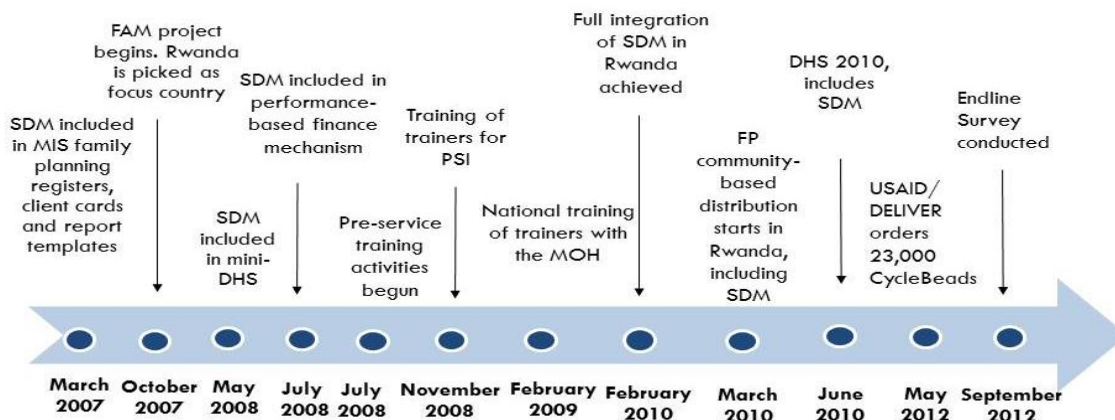
Monitoring data: In addition to annual measurement of progress toward benchmark targets (see below), IRH routinely tracked:

- *Service statistics* from health facilities. IRH monitored the number of new FP users by method, detecting SDM's share among the entire method mix and trends over time.
- *Knowledge improvement tool (KIT)* for quality assurance. IRH used this two-page checklist to verify provider knowledge of SDM counseling; after 2010, MOH and FBO partners also used the KIT. Data arising from KIT use helped refine the focus of supportive supervision and the content of refresher trainings.
- *Events timeline.* Tracking key events, and examining them semi-annually, helped IRH and partners detect internal and external influences on SDM scale-up and take appropriate actions.

ATTRIBUTES OF SDM THAT FAVORED ITS SCALE-UP IN RWANDA INCLUDE:

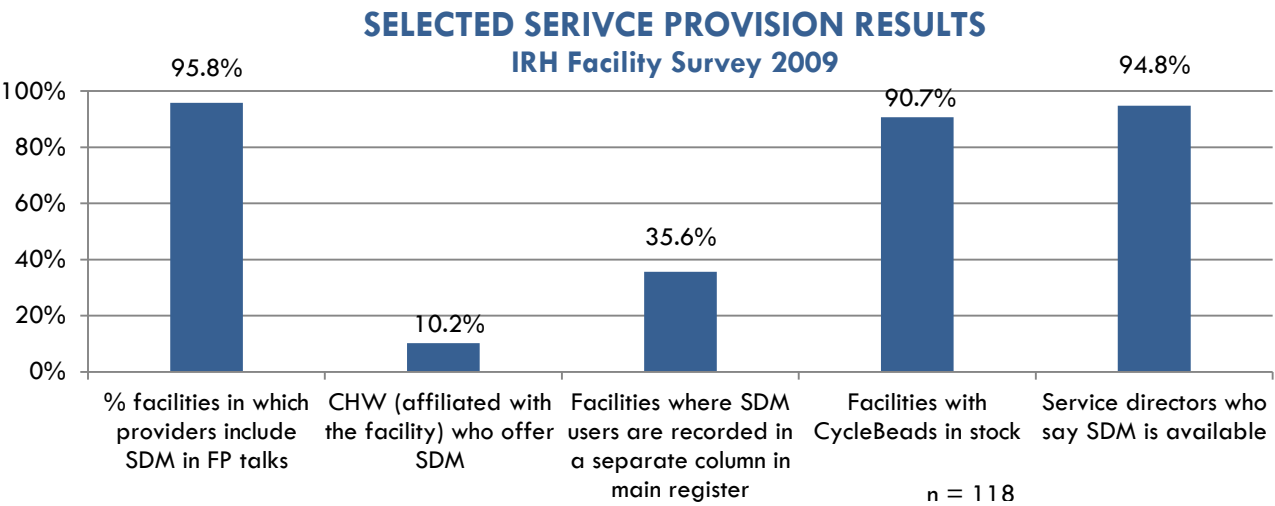
- Client satisfaction
- Male involvement
- Acceptance by churches and users whose religion discouraged the use of hormonal or barrier methods
- Ease and appropriateness of integrating SDM service delivery in health facilities and in communities.

The MOH, donors, and FBOs supported IRH's scale-up phase to increase access and availability, and to further institutionalize the method in Rwanda.



Evaluation studies: SDM scale-up in Rwanda benefitted from baseline and endline evaluations and additional research:

Baseline Scale-up assessment (2009): This IRH-commissioned study found that 94 percent of facilities visited had at least one provider trained to offer SDM. Among those trained, 87% had offered SDM in the year prior to assessment. Most providers could correctly counsel women how to use CycleBeads. However, a majority of trained providers incorrectly offered SDM to clients who did not know their cycle lengths or told such women to track their cycle before returning to the facility for CycleBeads. This was not consistent with the guidelines, and refresher training was needed to clarify this matter. The assessment found that only eight percent of facilities reported stock-outs of CycleBeads. However, many CycleBeads packages were missing the current calendar, instructions, and/or extra ring.



Stakeholder interviews (2009). A research consultant held in-depth discussions with FP stakeholders in Rwanda. The purpose was to record the insights of representatives of the government, NGOs, FBOs, donors and educational institutes into the political and environmental factors influencing SDM scale up, and their own and their constituents’ knowledge of and attitudes towards SDM and FP. Stakeholders recognized SDM’s value as part of the national method mix, and the importance of FBOs’ acceptance of SDM while the government was revitalizing FP as part of the national development strategy. Interviewees wanted to see stronger promotion of SDM, more service providers trained to offer SDM, and a wider variety of stakeholders advocating for SDM support among political and religious leaders.

Endline assessment results

A structured questionnaire (based largely on the contraception module of the DHS) and to measure SDM knowledge, current and ever use was administered in 2012. The endline was nationally representative and used multi-stage sampling to select 400 women of reproductive age and their male partners. About 95% of the women, and 88% of the men, had heard of SDM.

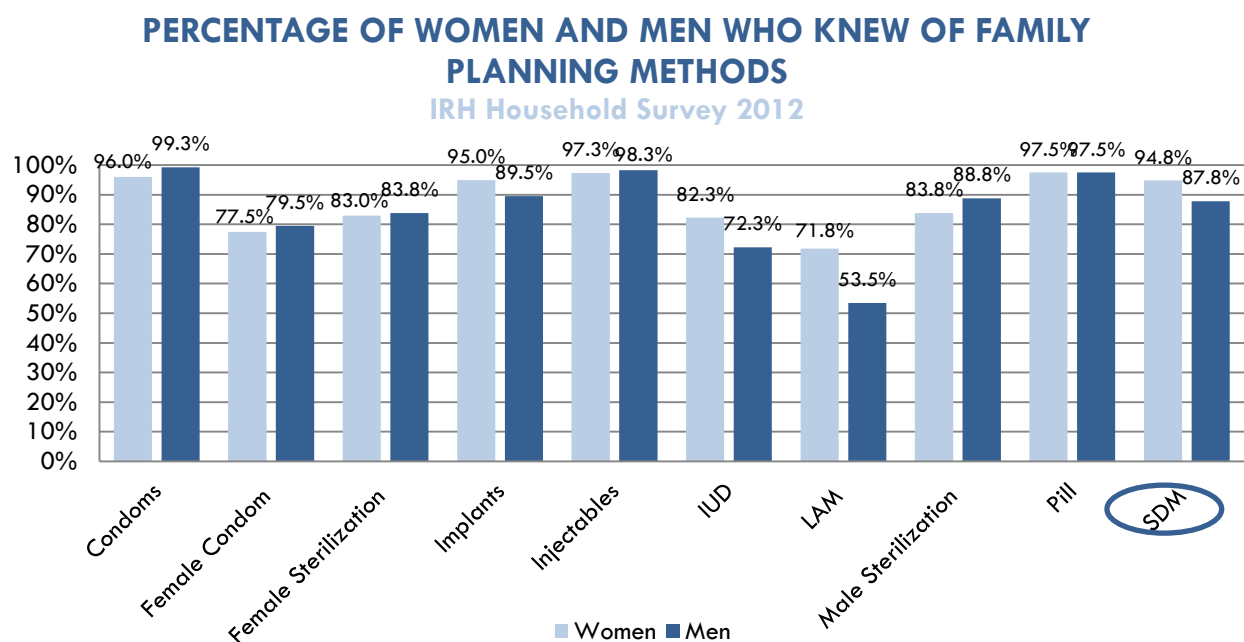
This compared favorably to knowledge of injection, the most commonly used method in Rwanda. Among women currently using a FP method, 7.4% were using SDM. Of the 400 women surveyed, 21 (5.3%) were currently using SDM and 25 (6.3%) had ever used the method. The four women who abandoned the method did so because their cycles were out of range. All SDM users demonstrated correct use of CycleBeads, and expressed satisfaction and intent to continue use.

Other components of the endline assessment were:

Community health worker interviews. Of the 73 CHW selected, most were able to counsel correctly, and there were few reports of stock-outs. However, about half of CHW said they asked women to track their cycle or wait for their next menses before providing SDM, creating an unnecessary medical barrier to first time users.

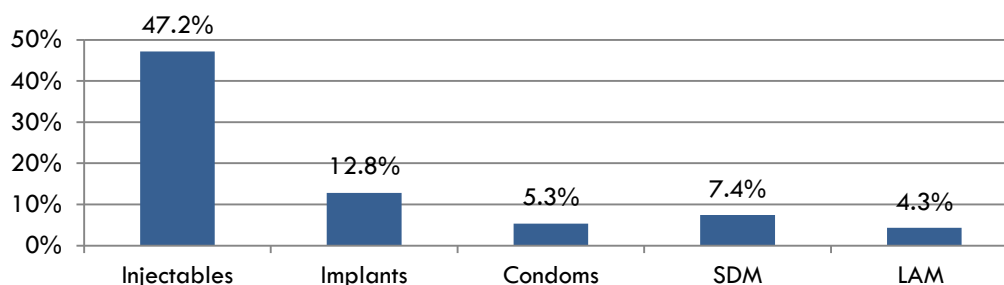
Simulated clients. This methodology detected some provider bias. Ten of 16 simulated clients whose profile suggested they were ideal candidates for SDM reported that they felt pressure to consider other options. Meanwhile, only nine of 16 simulated clients whose profile suggested injection felt they received enough information from service providers to make an informed choice.

Stakeholder interviews. A second round of stakeholder interviews in 2012 found unanimous agreement that SDM was appropriate to Rwanda's social and cultural environment. All interviewees expressed that the scale-up intervention played a pivotal role in bridging differences between church- and state-managed elements of the health system. All felt that SDM scale-up had been largely achieved, and that little if any provider bias remained. Most pointed to the MOH and FBOs when asked who was responsible for completing the few outstanding scale-up tasks.



METHOD USE AMONG WOMEN CURRENTLY PRACTICING FAMILY PLANNING

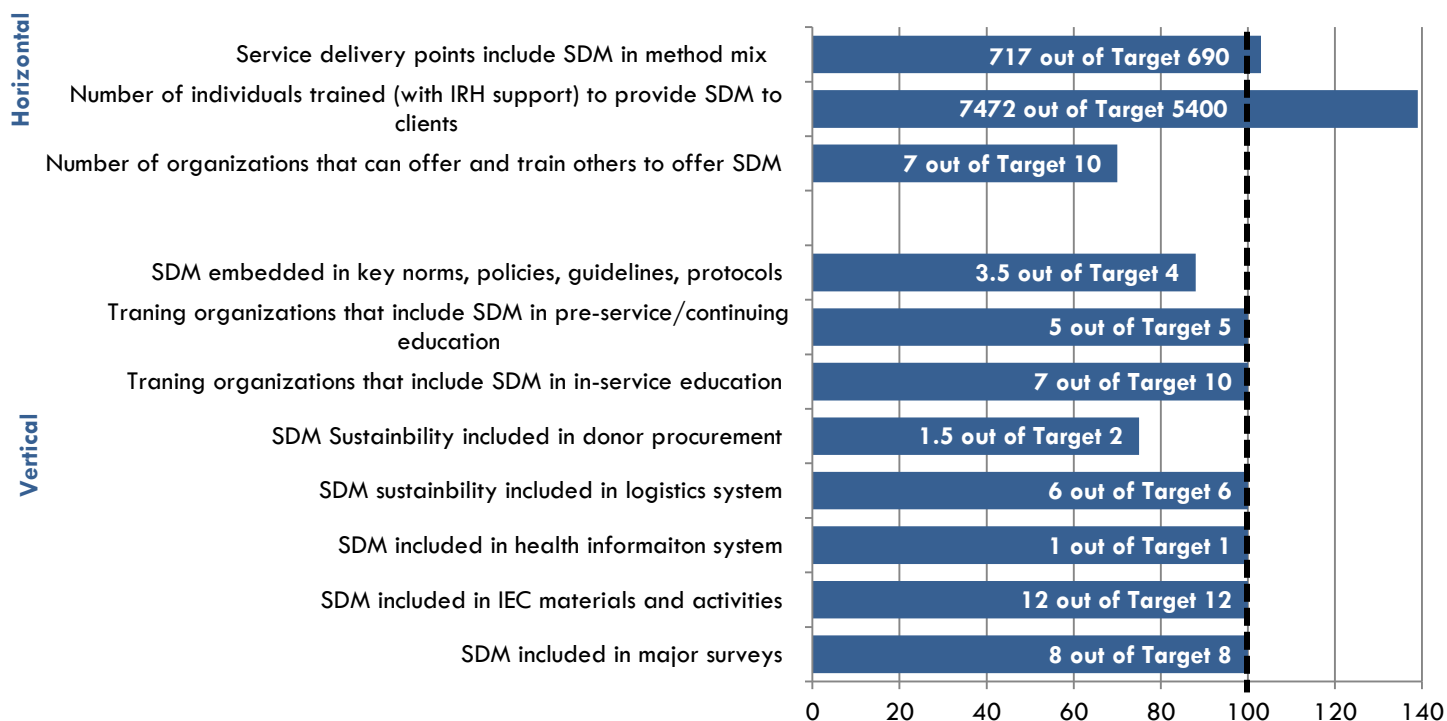
IRH Household Survey 2012



Achievement of SDM Benchmark Targets

The figure below shows overall strong achievement of benchmarks, both horizontal and vertical, in Rwanda. Each benchmark is then briefly discussed.

PROPORTION OF BENCHMARKS ACHIEVED, RWANDA



IRH’s work along the *horizontal* scale increased availability of and provider capacity to offer SDM across Rwanda. By the end of the scale-up phase, 717 service delivery points (103% of target) included SDM in their method mix.

These delivery points—health facilities, outposts,¹pharmacies—were in all 30 of Rwanda’s districts.

IRH directly supported the training of almost 7,500 individuals to offer SDM. This included both facility- and community-based health workers. The roll out of community-based provision of FP methods including SDM happened very quickly at about mid-point in the scale-up phase, and was a boon to SDM availability in the approximately one-third of Rwandan districts where USAID-funded projects were not supporting health service delivery.

Seven entities including the MOH gained the capacity to undertake the full range of SDM service provision including training and/or supervising others to offer the method. In ExpandNet terminology, these are resource organizations, and they are important for the sustainability of a health innovation. In addition to the MOH, resource organizations in Rwanda include Caritas and Action Familiale (two key FBOs), ARBEF (the national Planned Parenthood affiliate), and PSI (social marketer).

Activities on the *vertical* scale aimed towards the sustainable institutionalization of SDM in Rwanda. SDM was integrated into FP policies, norms and protocols, in-service and community health training manuals and supervision tools; in fact, this was achieved prior to the start of the scale-up phase. By the close of scale- up, however, SDM was not fully integrated into the government’s performance-based financing (PBF) system for health services. The method appeared as a unique (and thus countable) item in PBF’s 2009 reporting forms, but was dropped in 2010 and following years. Health facilities are financially rewarded only for services they can report; SDM’s absence from PBF forms may lead to provider bias against offering the method.

IRH achieved SDM integration into the FP pre-service training curricula before the scale-up phase began. The method was subsequently included in the in-service training provided by seven entities. IRH originally targeted ten entities, but three were donor-funded projects that ended while scale-up was still underway.

FP commodity procurement in Rwanda requires the coordination of several components. First, the FP TWG and another MOH unit meet and review data to determine the type and number of items needed. Second, the Medical Production and Procurement Department orders, tracks, transports and stores the FP commodities. Third, donors USAID and UNFPA commit to pay for the FP commodities. By the end of 2012, SDM was integrated into the first two of these components. In the third, only USAID procured CycleBeads. IRH advocated ceaselessly with UNFPA to procure them, and remained optimistic that it will agree and further sustain the method in Rwanda. The table at right shows the number of CycleBeads procured for Rwanda during the scale-up phase, and what entity purchased them.

CYCLEBEADS PROCURED IN RWANDA, 2007-2012	
ORGANIZATION	AMOUNT
USAID	76,100
IRH	4,000
PSI	2,500
Total:	82,600

¹ Where church-managed facilities chose not to offer FP methods, the MOH instigated a system of nearby outposts where clients could find the full range of methods including SDM/CycleBeads.

SDM was included in all of the targeted elements of the logistics system, including requisition and inventory tracking. It was also present in the health reporting system, at facility, district and central levels, by the midpoint of the scale-up phase. The method was included in all IEC materials and media diffused by the MOH and its partners: in this regard, SDM was treated like every other FP method in the national method mix. Finally, the method was included in all important surveys on FP and reproductive health in Rwanda in recent years, including: Demographic and Health Survey (2007, 2010), Barriers to Contraceptive Use Survey and Post-partum Contraception Study (2010, FHI), Service Provision Assessment (INFSS/MACRO, 2007) and others.

Scale-Up and the Rwanda Environment

SDM scale-up in Rwanda benefited from the country's political stability and the government's position that FP was a crucial development tool. That stance, which also held that uncontrolled population growth would prohibit individual and national well-being, steered government policy to promote long-acting and permanent contraceptive methods. IRH, in response, positioned SDM as a long-term use method, and specifically targeted policy and program decision-makers with this message. Donors, in part to align with MOH priorities, also tended to favor long-acting and permanent methods.

On the other hand, the strong influence of religion on Rwandan life and its health care system created a positive environment for SDM uptake. The scale-up process – notably, SDM's inclusion in reporting systems - also allowed FBOs to demonstrate their contribution to achieving national FP goals.

Most scale-up activity occurred in partnership with the MOH and with USAID-funded health projects. Two such projects—very large in geographic scale and influence on health services—closed in 2010. Eighteen months passed before USAID awarded a follow-on project; during this gap, key partners were not available to conduct training and supervision and provide general support to the FP program as a whole (and SDM in particular) in about two-thirds of the country.

Resource and User Organizations

As noted, a resource organization is one that promotes and facilitates wider use of a health innovation—in this case, SDM—while a user organization is one that implements an innovation. In Rwanda, the MOH had the staffing, structure and expertise to serve as the primary resource organization for SDM scale-up. Its Maternal and Child Health Task Force oversaw the scale-up process, while its FP TWG attended to technical tasks such as training trainers and instructors, and resolving CycleBeads distribution to health facilities. IRH, meanwhile, deliberately chose to play a dual role: as catalyst for scale-up processes, and as resource organization for the MOH and other resource organizations. It participated fully in FP TWG processes, and earned recognition as an innovative, experienced and politically neutral technical assistance agency for FP.

By the end of 2012, entities in Rwanda that qualified as resource organizations included the MOH, two influential FBOs, one NGO, and government bodies with specific roles such as the Kigali Health Institute (health worker training) and the Medical Production and Procurement Department (FP commodity procurement).

Strategic Choice Areas

The ExpandNet framework guided IRH to make strategic choices in several areas based upon a careful analysis of the operating environment in Rwanda. These areas, as they applied to SDM scale-up, are briefly summarized here.

Capacity building and technical assistance: One of IRH's priorities was to build technical capacity within the MOH so it could eventually operate autonomously as a resource organization, respond to SDM needs, and ensure SDM availability well into the future. A key IRH strategy was to integrate SDM training into the training, technical assistance and supervisory systems *already in place* in Rwanda's public sector. This reinforced those systems, reinforced SDM as an integral part of the method mix, and reinforced the competencies of existing MOH trainer-supervisors at central and district levels. Among notable training activities:

- The constant mobility of MOH health workers meant that refresher trainings were essential, and IRH spearheaded a series of them around the country.
- Health services in 23 of Rwanda's districts were supported by USAID projects, and the remaining seven were nominally supported by UNFPA. Yet that organization had no projects on the ground during the SDM scale-up phase. In these districts, IRH and the MOH trained MOH trainers in FP (including SDM), and these individuals subsequently trained providers in a cascade approach.
- Leading FBOs learned to provide trainings to church-managed health facilities, in some cases using materials IRH revised to exclude mention of condom use during the fertile period.
- When the MOH piloted community-based provision of selected FP methods, IRH offered its global CHW toolkit as a guide for curriculum development. IRH contributed to training plans, and seconded its training officer to the training of trainers.

RESOURCE ORGANIZATIONS IN RWANDA AS OF 2012:

- Action Familiale (AFR)
- ARBEF
- Central d'Achat de Medicaments Essentiels du Rwanda (CAMERWA)
- Caritas
- Intrahealth Capacity Project (since closed)
- Intrahealth Twubakane Project (since closed)
- Jhpiego MCHIP Bridge Project (since closed)
- JSI Deliver Project
- Kigali Health Institute
- MOH / MCH Division
- MOH / Nursing Division
- PSI

In the realm of quality assurance, IRH worked with the MOH to improve supportive FP supervision, with a particular interest in reversing the slight provider bias against SDM that was detected in several surveys. IRH used the KIT, as both a measurement and training tool, with the MOH and other user organizations, including FBOs. Data collected via the KIT in 2010 showed that service providers were performing quite well overall, but about 40% still had difficulty determining a client's eligibility to use SDM. To expand SDM coverage to the last seven districts in Rwanda, IRH and MOH established a system of Focal Points: district MOH staff who, during regular FP supervision, paid particular attention to SDM. They used the KIT to improve provider skills and knowledge of the method, and counteract any provider bias that arose.

Much of SDM integration into service provider training curricula took place prior to the scale-up phase. However, in 2007 the MOH and the Ministry of Education reorganized nursing schools and unified the nursing curriculum. IRH participated in the revision of the reproductive health segment and subsequent training of professors. Of note, the revised curriculum began with fertility awareness and the menstrual cycle, then moved logically to SDM as the *first* FP method presented to students.



Demand creation: IRH worked with several partners, including but not limited to members of the FP TWG, to raise awareness of and create demand for SDM, via channels such as radio, television and print media. Determined to go beyond these useful but standard approaches, IRH led and supported MOH and community-based organizations (women’s and men’s groups, and CHWs) to conduct an interpersonal communication campaign called *Each One Invites Three*, in which satisfied FP users distributed written invitations to non-user friends to visit the nearest facility or CHW to learn about contraception. The six-month campaign was largely successful – several districts saw a 39% increase in new users—and the MOH asked all FP partners to implement the campaign in their project areas.

Advocacy: SDM scale-up benefitted from a positive and supportive political and even cultural environment in Rwanda. The method was readily included in national norms, policies and curricula. Still, IRH continued to advocate throughout the scale-up phase, and in fact was an advocate not only of SDM but of informed choice for FP overall. Its stance was that SDM scale-up was an end in itself, but also a means by which the national FP program as a whole could be improved.

Monitoring and Evaluation: The systematic M&E plan has been outlined in the earlier section. Many different data sources were used to collect data to monitor scale-up processes and to evaluate outcomes.

Resource Mobilization: USAID ended its field support funding to IRH in 2009, but continued to purchase CycleBeads for Rwanda.

Key Elements that Facilitated Scale-Up in Rwanda

In addition to the positive political environment in which scale-up occurred, IRH noted several elements that favored SDM’s institutionalization and expansion in Rwanda:

- IRH is a small organization that operated through partnerships to amplify the effects of its work, and USAID’s strong support was very useful in cementing these partnerships. USAID commented publicly and privately about IRH’s technical and diplomatic skills, and the value of partnering with IRH.

- Likewise, MOH structures—notably, the Maternal and Child Health Task Force and the FP TWG—were able to witness the SDM scale-up process as one that contributed to FP revitalization as a whole. As scale-up progressed, IRH research was instrumental in eliciting commitment from task force and working group members. For example, when one study detected gaps in CycleBeads availability, a TWG partner took action to address the problem.
- IRH scaled up SDM in a way that supported a high-quality, national FP program overall, and not merely a single method within it. In 2010, the MOH asked IRH to build FP capacity at the district level—evidence that the institute had succeeded in positioning itself as an FP (and not only an SDM) advocate.
- The engagement of the FBO sector, particularly Caritas and its network of health facilities, allowed access to almost 40% of health facilities for SDM integration and also allowed creation of a sustainable relationship in FP programming between the MOH and Caritas.

Sustainability of SDM in Rwanda

Significant progress has been made across the various components of scaling up SDM at the national level. To assure that these achievements are sustained and/or advanced upon the end of the FAM project, however, there is a need to identify key actors and strategies that will move SDM forward in terms of advocacy, capacity building, logistics and procurement, IEC, and HMIS and M&E.

Scale-Up Component	Action for Sustainability	Responsible Party
Advocacy	<ul style="list-style-type: none"> • Advocate for re-insertion of SDM into the PBF system. • Lobby PSI (once it transitions to a Rwandan social marketing NGO) to include CB in their product line. • Advocate for Catholic FBOs providing SDM services outside of health facilities (e.g. Action Familiale) to have access to CB. • Advocate to FBOs to report their FP statistics to district MOH. 	USAID, MOH MCH Task Force and Community Health Desk, and MSH USAID USAID and MCH Task Force MOH FP Technical Working Group
Capacity Building	<ul style="list-style-type: none"> • Maintain SDM in national FP training materials and activities for facility and community level providers of FP. • Ensure SDM is part of FP activities in new bilateral projects (e.g. Chemonics Project Family Health Project). Existing staff have capacity already. 	MOH FP Technical Working Group USAID
Logistics and Procurement	<ul style="list-style-type: none"> • Continue CB procurement for the public sector. • Procure and supply CBs for use in private sector social marketing, including funding for promotion • Continue including CB in their 	USAID USAID PSI

	product line. <ul style="list-style-type: none"> • Access MOH condoms and replace inserts that include condom language with their own. 	FBOs
IEC	<ul style="list-style-type: none"> • Monitor SDM inclusion in new FP materials that are developed by the MOH or FP projects. 	MOH FP Task Force
HMIS/ Monitoring & Evaluation	<ul style="list-style-type: none"> • Systematically report FP statistics to district MOH to include in FP user statistics. 	Caritas & Action Familiale

Introduction

In the first decade of the new millennium Rwanda's Ministry of Health (MoH) made a commitment to strengthen its family planning (FP) program with the support of donors, bilateral and multilateral partners. Progress has been compelling: the modern contraceptive prevalence rate (CPR) leapt from four percent in 2000 to 45 percent in 2010.

The expansion and scale-up of the Standard Days Method (SDM)² was part of the reinvigoration of Rwanda's FP program in the post-genocide context. The combination of Rwandans' desire to space births, the traditional and religious beliefs of many Rwandans regarding contraception, and a renewed national focus on FP made the timing ripe for effective, easy-to-use fertility awareness-based methods (FAM) such as SDM. This report describes the work that the Institute for Reproductive Health (IRH), the MoH, and other partners undertook to scale up SDM from 2007 through 2012, following an introductory phase from 2002 through 2007.

Rwanda Context

Rwanda is home to an estimated 10.2 million people, most of whom live in rural areas and engage in subsistence agriculture. Rwanda is one of the most densely populated countries of sub-Saharan Africa: with a land area of just 26,338 km², it has more than 350 residents per square kilometer.

In the post-genocide context, the nation's fertility rate was high at 5.8 children per woman (2000), and the CPR had dropped from 13 percent (1992) to 4.3 percent (2000).³ The reasons for the declining CPR included a felt need, by the government and the population, to fill the void left by almost 1 million deaths in 1994. This compounded a cultural norm that favored families with many children.⁴

Religion has an important influence on FP in Rwanda. The 2010 DHS found that 42.7 percent of women respondents were Catholic, and 41.2 percent Protestant.⁵ Up to 40% of health facilities are managed or co-managed (with the MOH) by faith-based organizations (FBO). Most of these FBOs support the use of natural FP methods.

Yet Rwandan women did want to plan their pregnancies. The 2000 DHS revealed an unmet need for contraception of 32 percent among women in union – 20 percent for spacing and 12 percent for limiting pregnancies. At the same time, the national health system was missing opportunities to inform women of FP options: in 2000, only 22 percent of women visited a facility and were told about FP by a healthcare provider.⁶ High unmet need, low CPR, and increasing population density signaled an urgent need to improve and expand FP services in Rwanda.

The challenge was to determine how the FP program could be improved in the context of post-genocide pro-natalism. It was to respond to this crucial question that the government called upon all stakeholders to work together to revitalize FP in Rwanda. Expanding the range of available FP options was one way to improve FP services and make them more attractive to would-be users. As a natural

²IRH also revitalized the Lactational Amenorrhea Method (LAM); and piloted the Two Day Method (TDM). However, those methods have not yet reached the scale-up stage. This report deals solely with SDM.

³2010 Rwanda Demographic and Health Survey (RDHS) Fact Sheet. <http://www.measuredhs.com/pubs/pdf/GF24/GF24.pdf>

⁴Advance Africa, Deliver and Prime II 2002 chap. IV

⁵ 2010 Rwanda DHS report.

⁶Ayad, Mohamed, and Rathavuth Hong. 2009. *Levels and Trends of Contraceptive Prevalence and Estimate of Unmet Need for Family Planning in Rwanda: Further Analysis of the Rwanda Demographic and Health Surveys, 2000–2007/08*. DHS Further Analysis Reports No. 67. Calverton, Maryland, USA: ICF Macro. http://pdf.usaid.gov/pdf_docs/PNADQ640.pdf

method, SDM had the advantage of meeting the needs of couples who wanted a non-hormonal method or who objected to other methods for religious reasons.

IRH in Rwanda Prior to SDM Scale-Up (2002-2007)

In June 2002, USAID asked the Institute for Reproductive Health/Georgetown University (IRH) to offer technical assistance to Rwanda's MoH, and specifically its Division of Reproduction Health⁷, to introduce SDM in Rwanda. Increasing access to and use of FAM—and SDM in particular—seemed appropriate, given the religious and political environment described above, and the low knowledge of when in her cycle a woman could become pregnant (only 9 percent of women responding to the 2000 DHS could identify their fertile period). Because the government was in the process of revamping its FP program at the time, the environment for offering SDM was favorable.

Rwanda's MoH relied on donors for FP funding, and on NGOs and FBOs to support FP services. The primary donor influences in 2002 were USAID, which worked with government health centers in two-thirds of the country, and UNFPA, which provided budgetary but not technical assistance to the other third. IRH began its work in USAID-supported districts, and did so in partnership with the MoH and with PRIME II, a USAID-funded project managed by Intrahealth.

IRH used a research-to-practice approach for SDM introduction to 13 pilot sites. A small team of IRH, PRIME II and MoH staff trained providers, and supplied all tools and materials so they could offer SDM alongside other FP methods. MoH FP supervisors were also trained, and they integrated SDM into tools, routine statistics and pilot site resupply systems. Two years later, 15 more sites were added.

The introductory phase was evaluated in 2003 to inform future SDM expansion. Data were collected from the 13 initial pilot sites to assess the status of SDM use and knowledge after one year of service delivery.⁸ The evaluation found evidence of SDM acceptability (high satisfaction and correct use among users) and feasibility for integrating SDM into the method mix in Rwanda. (See box.)

SDM Introductory Phase: Key Results:

- Over 90 percent of women and their partners found it easy to manage the 12-day fertile period.
- Providers and clients found the method easy to teach, learn and use.
- Over 90 percent of SDM users correctly identified their fertile days, compared to 9 percent of women interviewed in the 2000 DHS.

The next evaluation took place in 2004/5, and was part of an IRH multi-country study to measure the effect of offering SDM in a concentrated geographic area on the quality and use of FP services. In Rwanda, data collection in one intervention district and one comparison district included three rounds of simulated clients, time series collection of service statistics, and a household survey. Results indicated a demand for the method: new SDM users represented five to 12 percent of all new FP users during period under review.⁹ The study further found that SDM could be integrated successfully into existing FP services, and confirmed that SDM helped involve men in FP.

In late 2006, a Community Health Workers' (CHW) Assessment showed that CHW were as competent as clinic-based health workers at informing people about the method. It was evident that more people could be reached with high-quality SDM services if CHW were allowed to offer the method.

⁷ Later named the Maternal Child Health (MCH) Task Force

⁸ The study included 174 female SDM users, 102 male SDM users, 57 community health workers, 25 providers, six supervisors, 16 women who conceived while using SDM, 14 female discontinuation cases, 60 female non-users, and 54 male non-users. (With the exception of ARBEF CHWs, other MOH CHWs did not distribute; they only promoted the method.)

⁹(MoH, and IRH, 2004)

Figure 1: SDM introduction in Rwanda, 2002-2006

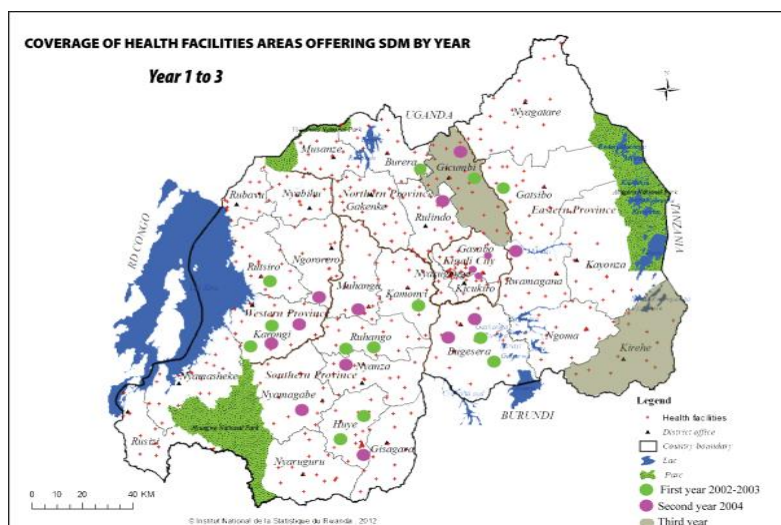
Overall, research during the introductory phase indicated that SDM had attributes that favored its scale-up in Rwanda: client satisfaction, male involvement, ease and appropriateness of service delivery at clinic and in community. This evidence (in particular, SDM's acceptability to clients), plus testimony from users and community leaders' visits to pilot sites, convinced decision-makers of the feasibility of including SDM in Rwanda's FP program on a larger scale.

The MoH integrated SDM into the new FP policies, norms, training curricula, management information and logistics systems that it developed from 2005 to 2007. The MoH and IRH involved all key FP partners¹⁰ in the development of SDM messages and the adaptation of SDM tools.

Within this favorable policy environment, geographic expansion of SDM services continued. In 2005, IRH and the MoH introduced SDM to 74 more sites in Rwanda, achieving coverage in about 20 percent of the country. From 2006 forward, IRH expanded SDM even further by working with a range of NGOs, FBOs and their projects:

- **IntraHealth**, which managed two USAID-funded health projects: **Capacity** (focusing on health facilities) and **Twubakane** (community mobilization). Both projects supported the MoH at central and district levels via trainings, supervision, production of IEC materials, and implementation of government policies (such as performance-based financing or PBF). IRH worked with both projects to make SDM available in facilities and communities, largely through provider training. The Capacity project was also a key player in integrating SDM in the pre-service curriculum for nursing schools, with the MoH and the Ministry of Education, with technical support from IRH.
- **Action Familiale Rwandaise (AFR)** trained trainers and teachers at the community level in six Dioceses to offer SDM, among other natural FP methods, as part of Family Life Education within the Catholic Church. IRH provided technical assistance and some financial support to this FBO.
- **Association Rwandaise pour le Bien Etre Familiale (ARBEF)**, an affiliate of the International Planned Parenthood Federation, operated a handful of clinics in Rwanda. IRH trained ARBEF trainers and providers at clinic and community levels to integrate SDM into the range of FP methods offered.
- **Deliver**, a JSI-managed, USAID-funded health commodities project, provided technical assistance to the MoH to ensure that health facilities had adequate CycleBeads stocks.

By the end of the introduction phase, more than 10,000 clients were registered, a number that represented between five and 12 percent of new users of SDM.¹¹ The table below summarizes the position of SDM at the close of the introductory phase.



¹⁰ UNFPA, WHO, USAID, Rwanda's Office of Population and others.

¹¹ MoH& IRH, 2004

Table 1: SDM Institutionalization and Expansion Achieved 2002-2007

Institutionalization	Geographic Expansion
<ul style="list-style-type: none"> MoH FP training manual (2003; revised 2007) Nationwide nursing curriculum (2007) FP policy and strategy 2005-2010 (2005) DHS (2005) IEC/BCC tools (2003 forward) National MIS (2004 forward) CAMERWA (MoH national logistics system) (2006 forward) MoH FP norms and protocol (revised 2007) MoH supervision tools 	<ul style="list-style-type: none"> Coverage: 74 sites in $\frac{2}{3}$ of Rwanda's 30 districts More than 800 providers trained to offer SDM 2,000 trained community mobilizers Capacity transfer to four organizations/projects in SDM service delivery without IRH assistance (ARBEF, AFR, Twubakane, Capacity)

Although much progress was made in SDM scale-up by 2007, considerable work remained, especially reaching the districts where SDM was not available, and transferring capacity to local organizations to offer the method. Data from the Service Provision Assessment, conducted by INFSS/MACRO in 2007, found that SDM's geographical coverage was 75 percent of health facilities, but that only 12 percent of facilities had CycleBeads in stock at the time of survey. This was one of the first times that SDM integration into FP services was being monitored by organizations other than IRH.

To expand SDM availability, the MoH coordinated a strategic planning meeting in February 2007, gathering all entities that participated in the SDM introduction, and several newly identified partners. The meeting's aim was to identify gaps in and establish priorities for completing SDM scale-up and sustainability. Participants used a model in which SDM was compared to a better-established FP method (in this case, oral contraceptives, which had been available in Rwanda for several decades) in a variety of measures that were considered indicators of sustainability. The methods were ranked 'start,' 'average,' or 'complete' across several components:

Table 2: Status of SDM Sustainability Rwanda, 2007 Strategic Planning Workshop

Components of sustainability	Pill	SDM
Integrated into governmental pre-service training curriculum at clinical, community levels.	Complete	Average
Integrated into in-service training and curriculum of the government at clinical and community level.	Complete	Complete
Integrated into governmental monitoring systems.	Complete	Average
Included in IEC materials.	Complete	Complete
Integrated into logistic system and products distribution	Complete	Complete
Funds allocated to purchase the products.	Complete	Average
Integrated into MIS	Complete	Average
Integrated into national policies	Complete	Complete

The components and SDM's ranking served as reference for planning further scale-up of the method. One conclusion from the workshop was that SDM was integrated into the system, but that certain gaps had to be addressed to ensure sustainability, including allocation of financial resources to purchase

HOW SUCCESSFUL WAS SCALE-UP OF SDM IN RWANDA?

As of December 2012:

SERVICE EXPANSION

SDM services available in 717 service delivery points and in all 30 districts of Rwanda (public, private)

Seven organizations including the MOH are able to build others' capacity to offer SDM

INSTITUTIONALIZATION

SDM fully integrated into national FP program and these sub-systems:

- Most norms, policies, guidelines
- MIS Reporting system
- Pre-service training curricula
- Logistics system
- National surveys
- MOH-sanctioned IEC materials

SDM USERS & KNOWLEDGE OF SDM OPTION

The majority of women (95%) and men (88%) had heard of SDM at endline.

SDM users comprised about 7.4% percent of all FP users. This is an indicator of successful scale-up, based on past IRH studies.

Of those who discontinued SDM, 100% cited their menstrual cycle was outside the eligibility range.

CycleBeads. Participant reflections also identified gaps in SDM availability and the extent of integration into normative documents and subsystems (supervision, for example). The workshop helped clarify which partners and stakeholders might serve as key allies as IRH transitioned from the introductory to the scale-up phase. Accordingly, IRH held one-on-one meetings with selected organizations after the strategy workshop, to define how SDM fit within the priorities and mandates of each, and to plan roles in and contributions to SDM scale-up.

For the next phase, IRH chose to work closely with MoH at both central and district levels for several reasons. IRH's own partnership principles encouraged such collaborations, and operationally, the MoH had a normative and legitimizing function for FP programs nationwide. Moreover, the MoH was well organized and had established inter-organizational mechanisms, such as the FP Technical Working Group (FP TWG)¹², for FP technical and program coordination. Collaboration and participation in planning had the added benefits of providing opportunities to revise training and supervision systems to include SDM. Finally, collaboration reaffirmed several principles of health systems strengthening: working with local partners who lead program development, and supporting workforce capacity-building and evolution (such as task-shifting of some FP services from facility to community level; see Section F).

Use of the ExpandNet Model in Rwanda

In the last quarter of 2007, IRH adopted the World Health Organization's ExpandNet Model for scaling up health innovations. IRH used the model in all countries where SDM scale-up was underway, and adapted it as needed to suit each country's operating environment and progress to date. The ExpandNet Model would help IRH and partners conceptualize and plan for the **five-year scale-up phase** from early 2008 to early 2013.

In Rwanda, IRH introduced the ExpandNet Model at the official launch of the scale-up phase in March 2008. This high-profile meeting set the stage politically for SDM scale-up, and was attended by the Minister of Health, the USAID Mission Director, and representatives of various organizations involved in FP. Also present were members of the FP TWG, and service providers and users who described their personal experiences with SDM.

¹² The FP TWG was a sub-committee of the Maternal Child Health (MCH) Task Force within the MoH. Its members offered technical support to SDM scale-up. See Section E.3 for further information on both these entities.

In its role as scale-up catalyst, IRH made extensive use of the ExpandNet Model to plan the multi-year strategy. Scale-up is a complex process that requires movement along both vertical (institutionalization) and horizontal (expansion) axes, in the midst of a constantly changing environment. Given the multi-faceted nature of scale-up, the model was extremely useful in clarifying for IRH and stakeholders what successful scale-up would look like and what would be required to achieve it. However, although IRH introduced the ExpandNet Model at the launch meeting, it did not use the model to organize partner roles, responsibilities, and commitments. The existence and function of the FP TWG structure in Rwanda meant that creating a separate resource team, guided by the ExpandNet Model, would be redundant. IRH continually referred to the model, however, and it remained the principal internal tool for planning and adjusting scale-up direction and choices as needed.

I remember in the beginning we talked a lot about 'extension'. Extension in 13 sites, extension in 15 new sites, and extension in 39 new sites. At that time, I never thought of institutionalization. I thought more about geographic coverage and horizontal integration than I did about vertical integration. But after the introduction of the ExpandNet Model, I realized that what we were doing was not enough. In fact it was only one aspect. I think everyone has to understand it as being a sustainable process. We should always add 'sustainable' [when we talk about scale-up], as not everyone understands [scale-up to mean] the same thing.

IRH Country Representative, 2011

The ExpandNet Model helped IRH maintain appropriate balance in its efforts to achieve both institutionalization (vertical scale-up) and geographic expansion (horizontal scale-up) and in Rwanda:

IRH's institutionalization of SDM during the scale-up phase focused on integrating SDM into health systems, and on transferring capacity to resource organizations (see Section E.3) to assure the quality of service delivery and continued commitment to SDM as an option in the method mix. Institutionalization also meant ensuring that policy gains made in prior years were not reversed.

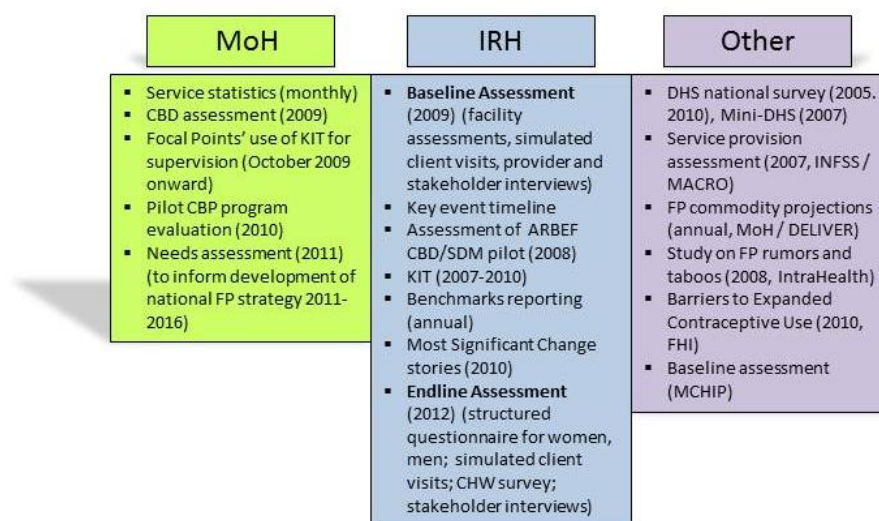
IRH's geographic expansion of SDM was conducted in a planned and organized manner. All activities were coordinated by the MoH through its MCH Task Force, whose membership included IRH and representatives from development partners, and the FP TWG. The MCH Task Force completed a mapping exercise in 2007 in which it divided the country into zones by major FP donor. USAID (via the aforementioned Capacity and Twubakane projects) covered much of Rwanda, and could support geographic expansion from a technical point of view. UNFPA zones, by contrast, did not have active programs on the ground. To overcome this gap, the MoH designated some of its own District FP Supervisors to serve as 'Focal Points' for SDM integration. (The Focal Point strategy is described in Section F.1.c.)

In all its internal, annual work plan meetings, IRH included a review of ExpandNet elements, complemented by a review of scale-up benchmarks (see Section D) to systematically determine areas needing attention in coming year. Information and decisions were then shared individually with scale-up partners, who planned their activities accordingly.

Data Sources, Collection and Analysis

IRH made use of an array of primary and secondary data, and routine monitoring information, to inform the scale-up process, identify successes, and detect gaps in quality service provision.

Figure 2: Major Data Sources during SDM Scale-Up



Primary Data Collection and Analysis

Baseline assessment of SDM scale-up, 2009: IRH commissioned a set of studies to determine the status of SDM scale-up and the extent of its integration into FP services at baseline.¹³ The study consisted of three major elements:

i. Facility assessment and provider interviews. A national sample of 118 facilities was systematically selected, including 91 (77 percent) run by the government and 27 co-managed by the FBO Caritas. All listed FP methods were available in the government facilities. All methods except sterilization (male and female), diaphragms and foam were available in the FBO-supported facilities or in their nearby health posts.¹⁴ One or two providers were interviewed at each facility for a total of 155 providers, most of whom (93 percent) were nurses.

Overall, results were very encouraging. Most service delivery points offered SDM, and 94 percent had at least one provider trained to do so. Among those trained, 87 percent had offered SDM in the past year. When asked about offering SDM in the past three months, providers who responded 'no' explained that clients did not choose it (57 percent) or cited a lack of training (40 percent), which IRH interpreted to mean that the facility still had no provider, including the respondent, trained to offer SDM.

Only eight percent of facilities reported CycleBeads stock-outs in the preceding three months (compared to 5 percent for oral contraceptives and 2 percent for condoms), suggesting that supply-chain problems detected by a separate study (see *Service Provision Assessment*, Section C.3) were largely resolved. However, items were missing from some CycleBeads packages: extra ring (missing

¹³ Rwanda Assessment Survey: Extent of Standard Days Method® Scale-up and Availability of Lactational Amenorrhea Method (LAM) within Health Services. December 2009. Washington, D.C.: Institute for Reproductive Health, Georgetown University for the U.S. Agency for International Development (USAID), and Kigali, Rwanda: Rwanda Ministry of Health.

¹⁴ To fulfill the MoH imperative of offering a full range of FP services, many FBO-supported health centers that offered only natural FP methods created nearby health posts that offered the full range of methods to clients. This system effectively expanded access to SDM because the method was offered in two places for each FBO facility.

from 21 percent of packages examined), correct insert (24 percent) and/or current calendar (64 percent).

Among providers trained in SDM, most could correctly teach women how to use the method. However, many refused to offer SDM to clients who did not know their exact cycle length or asked such women to track their cycles before beginning use. These providers were not following the guidelines, which state that a woman may start using SDM immediately provided her cycles last about one month. Refresher training was needed to clarify this matter.

ii. Simulated client visits. Results of the simulated client visits confirmed that providers exhibited knowledge gaps in screening for eligibility. Moreover, notes from simulated clients about their visits indicated ongoing provider bias against SDM. Again, refresher training was indicated.

iii. Stakeholder interviews. IRH hired a consultant to conduct in-depth interviews with key stakeholders (from government, NGOs, FBOs, professional associations, educational and training institutions, donors) on topics such as political commitment to SDM scale-up, political and environmental factors influencing SDM scale-up, and SDM knowledge and attitudes. (Stakeholder interviews were repeated at endline in 2012; see Section C.4.)

Key results from the 2009 interviews indicated that SDM was seen by all interviewed stakeholders as one of the FP methods offered in Rwanda by the MOH and should be supported as such. It was important to include a natural FP method that was acceptable to the Church, particularly as the Government was beginning full-scale support of FP programs as part of its national development strategy. But more work was needed, particularly in increasing SDM promotion, training more FP providers, and engaging a variety of stakeholders to increase political support from political and religious leaders and local authorities.

Most Significant Change (MSC) Stories, 2010: IRH introduced this inductive, indicator-free, participatory evaluation method to complement its more traditional deductive data collection methods. MSC involved gathering stories around predefined “domains of change”¹⁵ from those most immediately involved (such as FP clients, clinic staff, program managers). The three domains were (1) changes in the lives of SDM users; (2) changes identified by service providers since SDM introduction; and (3) changes signaled by program managers since SDM integration into the national FP program. By allowing respondents to describe the phenomena that they valued most, MSC uncovered scale-up processes and outcomes not detected by quantitative evaluations, and intangible aspects such as advocacy, leadership, gender equity and informed consent. As a participatory process that engaged key scale-up actors in story collection, analysis, and selection, the MSC process led to greater understanding of values and appreciation of SDM expansion by the MOH, ARBEF, CARITAS, AFR and served to refocus scale-up efforts by all involved organizations.

Routine Monitoring and Evaluation

As indicated in Figure 2 above, data for M&E came from a variety of sources, including the MoH, IRH, and other partners.

Project Monitoring Plan and Benchmarks: In 2007, IRH established a project monitoring plan that included specific targets, and benchmarks to measure annual progress towards those targets. IRH created a database in ACCESS to record information, and aggregated data into a benchmark tables twice a year. By comparing current figures to previous and target figures, IRH evaluated progress, identified problems, and determined adjustments as needed. See Section D below for more on benchmarks.

¹⁵ Davies and Dart, 2005

Service statistics: Service statistics from health facilities included the number of new FP users by method, including SDM, which allowed IRH to monitor the spread of SDM services in each district in comparison to other FP services, and to examine trends over time. Ideally, each health center shared its statistics with district authorities each month. The latter then sent data to the central level for compilation and analysis. Because this process was not always reliable, IRH hired a consultant to collect service data each year.

Knowledge Improvement Tool (KIT) for quality assurance: The KIT, a two-page checklist to verify provider knowledge of SDM counseling, was applied regularly by IRH during the introduction phase and in the early scale-up years to ensure the quality of SDM services offered at scale. In 2010, MoH Focal Points and partners including AFR and Caritas began using the tool in the seven UNFPA-supported districts that were the last to integrate SDM into FP services (see Section F.1.c). The data arising from the KIT help refine the focus of ongoing supervision visits and the content of refresher trainings.

Key Event timeline: IRH staff listed actual events as they happened, then twice annually entered them into a graphic timeline to record key internal and external events that positively or negatively influenced SDM scale-up. For example, the change in the Minister of Health was an important external event that could influence SDM scale-up. These events would be used at the end of the scale-up phase as information to help analyze scale-up success.

Other Research during Scale-Up

A 2008 *Service Provision Assessment*¹⁶ indicated that 75 percent of facilities that provided FP offered SDM; yet new user data did not show an expected concurrent increase in the number of SDM users. Further investigation revealed that CycleBeads were available in only 12 percent of facilities surveyed, suggesting that stock-out was a big problem influencing SDM uptake, and that considerable work remained to ensure sustainable SDM integration and scale-up in Rwanda. One of the scale-up partners focusing on commodity distribution systems, the Deliver Project, began to address the stock out issue. IRH's 2009 facility assessment one year later indicated that efforts to resolve stock outs were effective.

Some data collection tools developed by partners included questions pertaining to the SDM. For example, in its 2010 study on *Barriers to Expanded Contraceptive Use* in Rwanda, FHI reported that five percent of FP users chose SDM. This aligns with the 2003 Introduction Phase Study where SDM represented five to 12 percent of new FP users, and with IntraHealth's 2008 study of Gitega Health Center which found that 5.5 percent of new users chose SDM.

Endline Research

IRH hired a research agency in 2012 to implement a **structured questionnaire** based largely on the family planning section of the DHS, with an additional in-depth module about SDM awareness and use. This endline survey was nationally representative and used multi-stage sampling. The endline captured SDM awareness, and current use and ever use, while controlling for demographic characteristics. Other components of endline research were a CHW survey, simulated client visits, and stakeholder interviews.

Some 400 women of reproductive age, and 400 men married to these women of reproductive age, were interviewed. Overall, results of the household survey were very positive. About 95 percent of women and 88 percent of men had heard of the SDM. This compares favorably to the injection (the most commonly used method in Rwanda) which was known by 97.3 and 98 percent of respondent women and men, respectively. Six percent of women had ever-used SDM and 5.3 percent of all women

¹⁶ The survey was conducted by Rwanda's *Institut National de Formation en Sciences de la Santé* (INFSS) and MACRO International.

respondents were still using it at the time of the survey. The four women respondents who abandoned SDM did so not because they disliked the method or became pregnant, but because their cycles were out of range. All SDM users demonstrated correct use, said they were very satisfied with SDM, and planned to continue using it.

A total of 403 **CHW interviews** were held with a sample of trained CHWs randomly selected from a list of all CHWs affiliated with facilities in which CHW were trained. Although results were mixed, CHWs generally demonstrated correct knowledge of SDM counseling and reported relatively few stock outs. Some confusion over eligibility criteria was evident, and about half of CHWs said they asked women to track their cycle or wait for their next menses before providing SDM.

IRH conducted a second round of **simulated clients** at endline in 2012. Each of 16 facilities was visited by two clients. The profile of one client indicated that SDM would be an ideal option for her; the profile of the other indicated injection. Results suggest that appropriate service delivery of both methods was problematic, that providers appeared slightly more comfortable offering injections, and that provider bias persisted. Only 9 of 16 simulated clients with the injection profile felt that they received all the information they needed to make an appropriate choice. Meanwhile, ten of 16 simulated clients with the SDM profile felt pressured to consider other options.

Summary Assessment of SDM Scale-Up

The Benchmarks (Table 3) show the substantial achievements in SDM scale-up against the targets that IRH set for Rwanda, along both the vertical and horizontal axes.

Table 3: Rwanda SDM Benchmarks (updated July 2012)						
Rwanda end of project goals (by July 2012): <ul style="list-style-type: none"> Integrate the SDM into at least 95% of health facilities Integrate the SDM into at least 20% of Pharmacies and Private clinics through Social Marketing 						
Rwanda population coverage: 10,200,000 (estimated 2.4 million women of reproductive age and their partners)						
Horizontal scale-up	Year 1*	Year 2	Year 3	Year 4	Year 5	Target (n)
Proportion of SDPs that include SDM as part of the method mix	356 (51.5%)	379 (55%)	687 (99.5%)	687 (99.5%)	717 (103%)	690
Estimated number of individuals trained to counsel clients in SDM (IRH-supported)	1679 (31%)	2396 (44%)	2842 (52%)	6816 (126%)	7472 (138.3%)	5,400
Number of organizations that have capacity to undertake SDM activities (are resource organizations)	5 (56%)	6 (67%)	8 80%	7 70%	7 70%	10
Vertical scale-up	Year 1*	Year 2	Year 3	Year 4	Year 5	Target (n)
SDM included in essential or key policies , norms, guidelines, and protocols	2 (50%)	3 (75%)	3.5 (88%)	3.5 (88%)	3.5 (88%)	4

Presence of public or private training organizations that include SDM in pre-service training and/or continuing education	5 (100%)	5 (100%)	5 (100%)	5 (100%)	5 (100%)	5
Presence of public or private training organizations that include SDM in in-service training	4 (44%)	6 (67%)	6 (67%)	7 (70%)	7 (70%)	10
Sustainable inclusion of CycleBeads in donor procurement system	0	1 (50%)	1.5 (85%)	1.5 (85%)	1.5 (85%)	2
Sustainable inclusion of CycleBeads in logistics systems	5 (83%)	5 (83%)	6 (100%)	6 (100%)	6 (100%)	6
Inclusion of SDM in MIS /reporting systems	0.5 (50%)	0.5 (50%)	1 (100%)	1 (100%)	1 (100%)	1
Inclusion of SDM in IEC activities , materials and mass media	7 (55%)	10 (77%)	11 (92%)	12 (100%)	12 (100%)	12
Inclusion of SDM in surveys (e.g. DHS)	3 (37.5%)	4 (50%)	7 (87.5%)	8 (100%)	8 (100%)	8

*Includes achievements of the introductory phase

Horizontal Scale-Up or Geographic Expansion

Proportion of service delivery points that include SDM as part of the method mix

The number of service delivery points offering SDM increased annually. When the MoH instituted secondary health posts (offering a fuller range of FP options than available in some FBO-managed facilities), the number of service delivery points rose dramatically; see Years 2 and 3 in the table above. This was accompanied by the arrival of new scale-up partners (AFR, PSI) that began to offer SDM. Health staff transfers, and the training of master FP trainers in SDM, meant that some facilities began to offer SDM spontaneously, further contributing to growth in this indicator.

Estimated number of individuals trained to counsel clients in SDM (IRH-supported)

Various cadres of service providers were trained and counted, including providers in health centers, community health agents/community based provision (CBP) agents. The rollout of the CBP agents occurred very quickly, which significantly contributed to number of individuals trained. (This compensated for the slow training of providers and community agents in UNFPA-supported zones.)

Number of organizations with capacity to undertake SDM activities (are resource organizations)

Ten organizations were identified for and received capacity building in SDM services, including the MoH's MCH Task Force, the Community Health Services Desk, Caritas, IntraHealth Twubakane Project, ARBEF, PSI, Action Familial, IntraHealth Capacity Project, JSI/Deliver, and JHPIEGO's MCHIP. Three projects (Twubakane, Capacity, MCHIP) closed before 2012 and were removed from the list, leading to a 70 percent achievement by the end of the scale-up phase. This reflects the transient nature of NGO projects, although project staff often continue in technical FP positions in similar follow-on projects and capacity is not really lost.

See E.3 for further discussion of the role and activities of Resource Organizations.

Figure 3: SDM Availability in Rwanda, 2007 and 2010

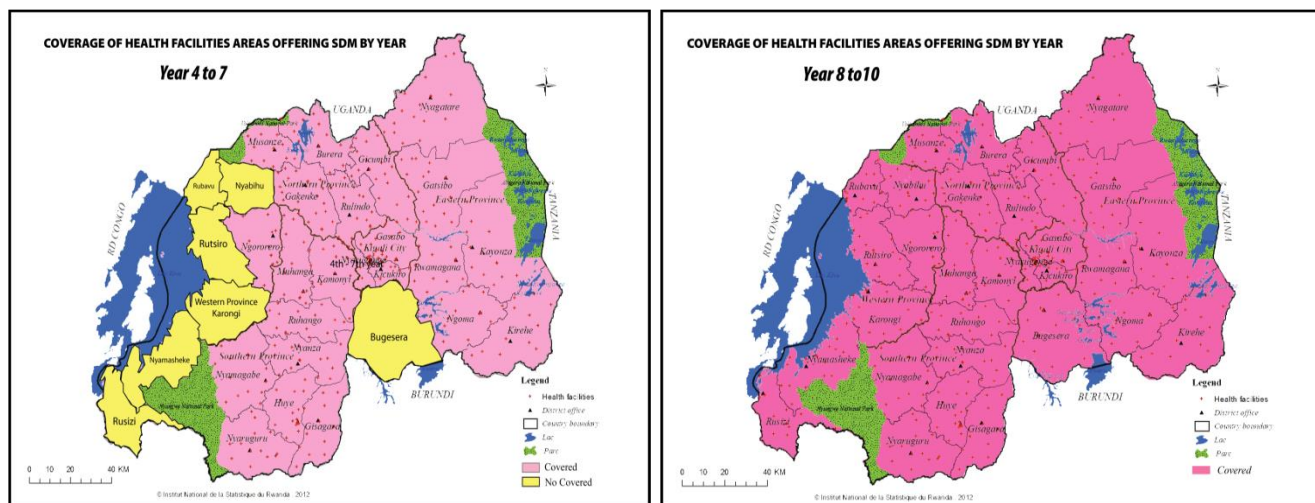


Figure 3 shows the progression of SDM availability from 2007 to 2010. Most districts that lacked SDM coverage (in yellow on map at left) at the onset of the scale-up phase were designated by the MoH as ‘UNFPA-supported’ (pink districts were USAID-supported). At the time, UNFPA was providing funding for reproductive health and FP in those districts, but had no projects on the ground. To reach full coverage by 2010 (map at right), IRH and the MoH implemented a Focal Point strategy (described in Section F.1.c) to achieve coverage goals.

Vertical Scale-Up or Integration

SDM included in **key policies, norms, guidelines, and protocols**

As noted in the introduction, much of the institutionalization of SDM was completed before the scale-up phase began: SDM was in FP policies, norms and protocols, in-service training manuals, supervision tools, community health training manual. Only the performance-based financing (PBF) did not achieve lasting integration of SDM: the method was inserted into but later removed from the PBF reporting forms that are the basis of the system.

Presence of public or private training organizations that include SDM in **pre-service training**

Five pre-service nursing schools were targeted to integrate SDM into their FP modules and, because a system-wide revision of FP training was underway prior to the scale-up phase, the method was already added in the national nursing curriculum. During scale-up, IRH advocacy efforts supported continued revisions to the curriculum and expanded training of preceptors and faculty, thus achieving full scale integration. See Section F.1.b for more information on pre-service training.

Presence of public or private training organizations that include SDM in **in-service training**

Ten groups that offered in-service training were targeted for integration of SDM into their FP training. Seven were achieved. (The three projects that closed before 2012 were eliminated from the ‘achieved’ group, resulting in a 70 percent outcome.) See Section F.1.b for more information on in-service training.

Sustainable inclusion of **CycleBeads** into donor procurement system

All FP commodities are managed by the Medical Production and Procurement Department (formerly managed by CAMERWA). Procurement ordering is done by the FP TWG and the Logistics TWG, who

together manage commodities procurement. Donors meet regularly to make commodity purchase decisions; USAID and UNFPA are the main donors for contraceptives. USAID is the sole procurer of CycleBeads as this report is written. UNFPA has not yet committed to CycleBeads purchases. IRH considers the integration of CycleBeads into planning and purchasing systems a partial achievement, and is hopeful that UNFPA will agree to purchase CycleBeads in order to achieve greater sustainability of SDM in Rwanda. Table 4 shows procurement by projects and donors during the scale-up phase.

Table 4: CycleBeads Procurement History in Rwanda

<i>Year</i>	<i>Who Ordered</i>	<i>How Many</i>
2007	USAID (IntraHealth/Twubakane Project)	19,600
	USAID (IntraHealth/Capacity Project)	6,500
	IRH	1,000
2009	PSI	2,500
2012	IRH (for PSI)	3,000
2007-2012	USAID (Deliver Project)	50,000
Total CycleBeads Procured 2007-2012		82,600

Sustainable inclusion of CycleBeads into logistics systems

IRH identified six components of the logistics systems into which SDM needed to be integrated: community, health center, district monthly inventory reports, central inventory report, commodity requisition forms, and availability of CycleBeads at the central warehouse. SDM was included in all six components by the midpoint of the scale-up phase.

Inclusion of SDM in MIS/reporting systems

SDM inclusion into MIS/reporting systems meant its presence in central, district, and health facility level reporting. The method was included in all three, and hence system-wide, in Year 3 of the scale-up phase.

Inclusion of SDM in IEC activities, materials and mass media

SDM is included in the IEC materials and media (newspaper articles, health education talks, community talks, radio, and many print materials) that are diffused by the MoH and its partners, by virtue of being among the MoH-sanctioned range of methods. See Section F.2 for a discussion of IEC, awareness-raising and demand creation in Rwanda.

Inclusion of SDM in surveys

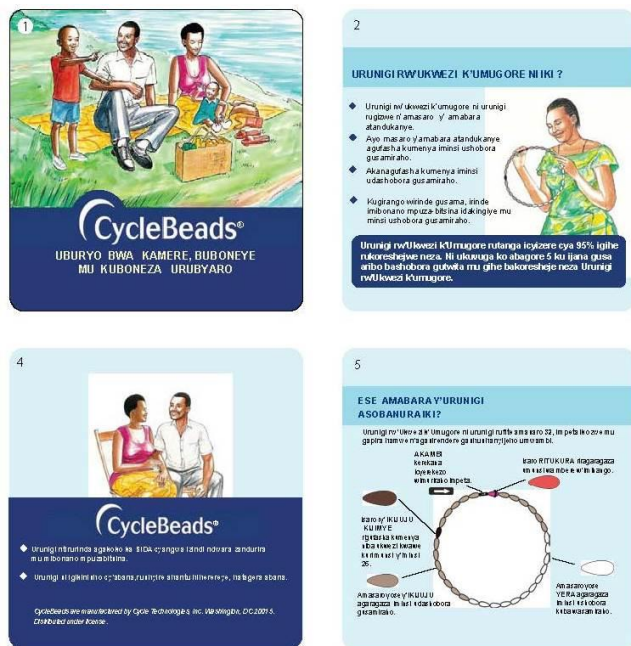
SDM has been included in important surveys and studies since the 2005 DHS. Boxes marked 'MoH' and 'Other' indicate non-IRH research in which SDM has been treated as a unique FP method. (See Figure 3 above).

Analysis of Scale-Up as Function of ExpandNet Elements

How the SDM Innovation Evolved during Scale-Up

The SDM innovation 'package' is composed of a CycleBeads package (the beads, a user instruction insert, and a calendar insert), training curricula for health providers, M&E tools (including the KIT), and awareness-raising and IEC materials. All of these components evolved over the scale-up period, with changes driven by scale-up and user concerns.

Figure 4: Portion of CycleBeads Insert in Kinyarwanda



CycleBeads package containing user instructions and calendars. During the introductory phase, user instructions were simplified and translated into Kinyarwanda. A four-year calendar insert replaced the one-year calendar. These modifications improved users' ability to follow instructions, and reduced the need to resupply calendars.

A second round of package changes occurred when PSI began to socially market CycleBeads, under the brand *Collier Confiance*, through private sector pharmacies. New packaging was created to make the product more visible to consumers in pharmacies. PSI also chose to translate the word CycleBeads into Kinyarwanda—*urunigi*—to make the product more understandable to consumers.

SDM in-service training materials. To facilitate the seamless integration of SDM into FP training in Rwanda, IRH modified training materials at

several junctures during the introductory and scale-up phases. In 2009, IRH revised its *global* guidance for determining user eligibility during counseling, and training materials in Rwanda were updated to reflect these changes. At that time, IRH shortened and simplified the SDM training curriculum into a 1.5 hour module. Finally, as the MoH began piloting community-based provision (CBP) of FP information and methods in 2010, IRH contributed to the development of a new SDM module for this cadre of health volunteers.

KIT supervision tool. As noted in Section C.2, the KIT is a two-page checklist used to assess retention and application of knowledge and skills among providers trained to counsel clients on SDM. To facilitate its use in general FP supervision, the KIT was shortened (that is, some questions were eliminated). Since the KIT did not encompass all FP methods. However, a multi-method KIT that includes SDM was finalized and field tested in Kenya and India in 2012. Subsequently, IRH and the Rwanda MOH plan to introduce this kit to Rwanda FP stakeholders as an integrated quality improvement tool for use in all FP services in 2013.

Awareness-raising messages, materials, and strategies. Awareness-raising materials and approaches developed for scale-up are specific to SDM and thus considered part of the innovation package. In the introductory phase, most IEC was clinic-based and printed—in effect, the CycleBeads insert and posters that announced the new method. By late 2009, as access to SDM increased but user numbers were lower than anticipated, the need for IEC to create demand became apparent. IRH and other stakeholders invested in several awareness-raising and demand creation activities. See Section F.2 for more on this topic.

Materials used by FBOs. Between 30 and 40 percent of health services in Rwanda are supported by the Catholic Church. The MoH and church (through the FBO Caritas) have a long history of successfully co-managing health facilities, and any facility co-managed with the government is expected to offer FP services, on site or at a nearby outpost. These facilities use the SDM package and informational materials described above. However, some FBOs such as *Action Familiale Rwandaise* offer natural FP methods as a component of their pastoral work – that is, outside the confines of the health system. IRH developed materials for such FBOs that do not mention the use of condoms during the fertile period.

Effect of Environment on Scale-Up

Governmental factors

IRH's work in Rwanda benefitted from political stability and a government vision of FP as a crucial development tool. However, policy discourse focused strongly on promoting long-acting and permanent methods, and this tended to undercut the legitimacy of SDM. In response, IRH worked to position SDM as a long-term method that should be considered among long-acting methods, and specifically targeted policy and program decision-making audiences. This was in addition to consciously positioning SDM as a method that contributes to the healthy timing and spacing of pregnancies, that involves male partners more than most FP methods, and that increases women's efficacy through knowledge of fertility. These positions were reflected to varying degrees in all training, IEC and advocacy materials.

Another governmental factor was frequent staff turnover. Since 2007, there were four Ministers of Health, three leaders of the MCH Task Force, and significant turnover among District Health Managers. In consequence, IRH and members of the MCH Task Force devoted time to educating incoming leaders on SDM and the scale-up agenda; often, this required work to change negative attitudes towards fertility awareness-based methods.

Donor Priorities

Although FP was also a priority for donors and the projects they supported, they—like the MoH—tended to favor long-acting and permanent methods. IRH's concern, reaffirmed by communication campaign evaluations elsewhere, was that communications emphasis on promoting Jadelle, vasectomy and IUDs affected consumer demand for SDM.

Donor influences in other aspects of health care had an indirect, yet important, influence on scale-up. Most notable were funding streams from the U.S. President's Emergency Fund for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The former left the MoH with fewer financial and human resources for FP program imperatives given the disproportionate financial and staffing shift towards HIV/AIDS programs. The latter financed a PBF system for the MoH, which essentially created financial incentives for health centers based on the quantity and quality of specified services that they delivered. FP services were part of the PBF, but SDM's inclusion as a reportable service factor was inconsistent. The method was included in 2009 but removed in 2010. Providers thus had a financial incentive to offer other FP methods, but not SDM.

Donor Funding

USAID in Rwanda provided field support funds from 2002 through 2008; IRH used these to provide technical assistance for SDM introduction and early scale-up. Since 2009, IRH's work in Rwanda relied exclusively on core funds from the global FAM Project, although USAID continued to support SDM integration by including CycleBeads in its commodity purchases for Rwanda. UNFPA, the other major FP donor, played an important policy role in Rwanda but was not publicly favorable to SDM.

IRH detected several consequences of this limited donor support, both financial and political, for SDM scale-up. Funding constraints meant that certain activities, such as awareness creation through mass media campaigns, were sporadic. NGOs implementing USAID-funded projects may have perceived IRH and SDM scale-up as unimportant because the donor did not support them directly. On the other hand, limited UNFPA and USAID engagement also served IRH well in that the MoH perceived the Institute as a neutral actor and increased its engagement in IRH activities as a result.

Discontinuity of resource organizations

Most scale-up activity occurred via IRH partnerships with the government FP program and with USAID-funded health projects. Two of the latter—the very large-scale Capacity and Twubakane projects that were important Resource Organizations — ended in 2010 and a gap of 18 months ensued before USAID awarded a new contract to an implementing NGO. This meant that key scale-up partners were not available to conduct training and supervision of FP (including SDM) in two-thirds of the country. Note that this gap affected not only SDM scale-up, but the public-sector FP program more generally.

Religion

The Catholic Church is an important actor in Rwanda. As noted, it manages or co-manages up to 40 percent of health facilities, and many Rwandans are practicing Catholics. Because the church viewed SDM as a natural FP method, and given long-standing church support for natural FP generally, many Rwandans were aware of and open to natural FP use. This created a positive environment for SDM scale-up. Stakeholder interviews during the endline assessment indicated that, prior to scale-up, FBOs struggled to prove to the MOH that church-run facilities could contribute to achieving national FP goals. By collaborating with IRH to advocate that SDM and natural methods be explicitly captured in the national MIS, such facilities were able to demonstrate their contribution to the national FP program.

The state's stance was that the church wasn't doing anything—that it just talked about natural methods and didn't have any results...[FBOs] were proud of how they worked, but needed...to get credible data to the MOH. At the time, the MIS had no category for natural methods. With advocacy with [IRH], they made that happen. They were able to show data for natural family planning.

Caritas M&E Officer

Resource Organizations

According to ExpandNet terminology, a *user organization* is an institution that adopts and implements an innovation. A *resource organization* is one that promotes and facilitates wider use of the innovation.¹⁷ In Rwanda, the MoH was the primary user organization, but it also played a lead role as a resource organization. It oversaw two inter-organizational coordination bodies that played key roles in scale-up:

1. The Ministry-led **MCH Task Force** was composed of representatives from the MoH and from donor, INGO, NGO, and sometimes FBOs working in MCH and FP. This body had primary oversight of the scale-up process. It played a political role to ensure that the necessary approvals were in place for SDM scale-up, and it coordinated resolution of problems as they arose.
2. The Ministry-led **FP TWG** was a sub-group of the MCH Task Force and provided technical input to scale-up. Members, who included representatives of the MoH and from donor, INGO, NGO, and sometimes FBOs working in MCH and FP, were dedicated to ensuring widespread access to a range of FP services and products. Adding SDM was a way for them to increase method options in Rwanda and reach more people with FP services. The FP TWG worked to achieve goals such as revising training curricula, training trainers and pre-service instructors, addressing gaps in CycleBeads distribution to health center level, and developing/revising FP materials to include SDM.

IRH served as a resource organization and as the primary catalyst to the scale-up process: it was, in essence, the ‘resource organization for the resource organizations.’ IRH was consistently present at the MCH Task Force and FP TWG meetings, and engaged in ongoing advocacy, capacity building, awareness-raising and M&E activities for SDM throughout the scale-up phase. IRH gained recognition as an innovative, experienced and politically neutral technical assistance agency for FP, and the Country Representative was often called upon to participate in or support related committees. For example, IRH

¹⁷ Refer to ExpandNet's *Nine Steps for Developing a Scaling-Up Strategy*. ExpandNet/WHO, 2007.

was a member of: the national team of FP Trainers, a sub-committee on IEC, and a group of CBD implementers. Due to IRH's unique experience in SDM, its support and/or oversight was considered necessary to ensure the high quality of any activity that included SDM.

In addition to IntraHealth (Twubakane and Capacity Projects), ARBEF (IPPF affiliate), AFR (working with natural FP teachers in Catholic Church Dioceses), and Deliver (CycleBeads logistics), the following organizations became resource organizations and contributed to SDM uptake during the scale-up phase:

- **Caritas:** With IRH assistance, this FBO, which co-manages about one-third of Rwanda's health centers with the government, trained trainers and providers to offer SDM in those facilities. According to Caritas service statistics, 3,690 clients chose SDM out of 7,807 total natural FP users, representing 47 percent of all natural FP clients, from 2009 through 2011.
- **PSI:** Through a sub-agreement with IRH, PSI included CycleBeads in its line of socially-marketed contraceptives. It developed new instructions and packaging, and integrated CycleBeads into branded and general contraceptive media campaigns. By the end of three years (2010-2012), 7,783 CycleBeads had been sold in private pharmacies and clinics.
- **Urunana DC:** This communications agency produced a widely-followed radio soap opera that integrated health messages in storylines. IRH and Urunana wove SDM messages into several episodes to raise awareness of/create demand for the method.

Table 5 lists all resource and user organizations and their role in SDM scale-up in Rwanda. Most resource organizations are also implementing agencies with health expertise, and IRH was able to build their SDM competency rapidly. Some user organizations, by virtue of providing technical assistance to peer agencies or clinics within their catchment area, became resource organizations.

Table 5: Scale-up Partners by Role and Involvement in Scale-up

Organization	Received IRH funding?	Active as of 2012?	Role in SDM scale-up	Resource or User Organization?
Action Familiale (AFR)	Y	Y	Integrated SDM into natural FP services at parish level	Both
ARBEF	Y	Y	Piloted community-based SDM services, integrated SDM into ARBEF clinic services	Both
Central d'Achat de Médicaments Essentiels du Rwanda (CAMERWA)	N	Y	Added SDM to MOH-branch dealing with public sector FP commodity projections, procurement and distribution systems	RO
Caritas	Y	Y	Integrated SDM church/state-managed health services	Both
IntraHealth Capacity Project	N	N	Technical assistance (project ended 2010)	RO
IntraHealthTwubakane Project	N	N	Technical assistance to build MoH FP capacity, including training of trainers, curriculum revision (project ended 2010)	RO
Jhpiego MCHIP Bridge Project	N	N	Technical assistance (project ended Sep2012)	RO
JSI Deliver Project	N	Y	With CAMERWA, improved procurement and distribution systems for FP commodities	RO

Kigali Health Institute	N	Y	Integrated SDM into pre-service nurse and other health worker training	RO
MoH / MCH Division	N	Y	Integrated SDM into: (a)FP norms and protocols, (b) Community Health Provision, (c) HIV/FP services	RO
MOH / Health Services Network	N	Y	Integrated SDM into FP services in health facilities and community outreach	UO
MOH / Nursing Division	N	Y	Integrated SDM into pre-service nurse-training	RO
PSI	Y	Y	Integrated SDM into private sector FP services and private pharmacies	RO

NB: The USAID Family Health Project was not yet operational at reporting time. It will have an FP component. Project staff will be continued from prior projects (Capacity, Twubakane, MCHIP); all were trained in and trained others in SDM. IRH expects that Family Health Project will be able to operate almost immediately as a resource organization.

Commitment of resource organizations to SDM scale-up

While all resource organizations outlined in Table 5 became competent to promote and deliver SDM services, competency was not the only essential attribute. Commitment was also crucial, because sustainability required that resource and user organizations continue to support SDM service delivery once the scale-up phase ended. Although SDM became far more institutionalized throughout Rwanda, it is unclear if commitment to SDM was transferred to all resource and user organizations along with technical capacity.

In some cases, such as PSI's social marketing project, strong CycleBeads sales led to high levels of commitment; PSI was motivated to continue including CycleBeads in its FP product line. Despite this fact, PSI must find a way to procure CycleBeads because USAID does not procure contraceptives for the private sector, and PSI's primary donor [KFW, a German development agency] indicated no plans to purchase CycleBeads. IRH provided the initial supply to PSI, and an emergency bridge stock in 2012 in response to growing demand.

In light of MoH and donor emphasis on long-acting and permanent FP methods, and given that SDM user numbers at MoH clinics were not as high as other methods throughout the scale-up phase (hovering at around five percent of new users), it is not clear that government and donor commitment increased over the scale-up period. However, some positive signs point to strong commitment to SDM services in Rwanda. For example, in 2011 an Austrian NGO attempted to start a cottage industry in Rwanda, in which women would make fertility awareness necklaces as a microenterprise. The introduction of this beaded necklace to the marketplace was confusing to actual and potential FP users.¹⁸ When the MoH raised this issue with the MCH Task Force, members had to make a choice to allow or ban continued production and sale of the home-made fertility necklaces, which had diplomatic and financial ramifications. In the end, the MCH Task Force upheld the integrity of SDM and forced the Austrian NGO to halt production. This was an important victory for the FP TWG (effectively the SDM resource team). Because the MCH Task Force had been involved in SDM scale-up from the beginning, it was willing to defend the method.

¹⁸ Note that SDM is a scientifically tested FP method that relies on a fixed fertile period to establish a 95 percent effectiveness rate, and the CycleBeads product is produced in a manufacturing facility with stringent quality control. The Austrian NGO's fertility necklaces did not share these characteristics, and their use could have resulted in unwanted pregnancies, which in turn could have damaged SDM's credibility and trust on the part of consumers.

Challenges

As mentioned, IRH devoted considerable effort to developing the USAID-funded Capacity and Twubakane projects into resource organizations, and they became significant sources of technical assistance to MoH facilities. When the projects ended in 2010, so did their contributions as resource organizations. After a gap of about 18 months, USAID awarded a new project in the same districts; its mandate also included technical assistance to the MoH in key health areas. Because many staff were carried over from the two earlier projects, IRH foresaw that the new project could become a resource organization fairly easily. Still, the uncertainty that persisted between 2010 and 2012 meant that it was difficult to plan for SDM sustainability. In Rwanda as elsewhere, reliance upon donor-funded, short-term projects to support or deliver health services clouds the question of long-term sustainability.

The absence of resource organizations in UNFPA-supported areas also posed challenges: no bilateral agencies with technical and financial support were operating in the areas. Consequently, no trained MoH trainers were on the ground and able to conduct trainings and provide oversight to SDM scale-up with non-MoH resources except during the six month period of MoH focal points in 2011.

User Organizations

The primary user organization in Rwanda was the MoH, which operates the majority of the country's 394 health centers. Caritas was another major user organization: the FBO co-manages, with the MoH, a third of Rwanda's health facilities.¹⁹ Sections C.1 and C.3 above described studies (and their results) of the quality and availability of SDM service provision via health facilities.

IRH's stakeholder interviews in 2009 provided insight into factors that affected the capacity of user organizations to offer SDM. Interviewees indicated that SDM, and indeed FP in general, did not seem to be a priority for health centers that suffered from a shortage of providers. Rather, they concentrated their limited resources on curative care. By the time FP stakeholders were interviewed again in 2012, the capacity issues had become more focused. A greater number of respondents stated that it was up to both the MoH and church leaders to develop and implement post scale-up strategies to maintain achievements, notably: ongoing training, supportive supervision of service providers and district trainers, a consistent supply of training materials, and special strategies to reach specific groups (youth, women's associations).

Continued Analysis of ExpandNet Elements: Strategic Choice Areas

Capacity Building and Technical Assistance

To promote informed choice and strengthen the FP program as a whole, IRH ensured that, with few exceptions, SDM training was conducted within the training, technical assistance, and supervision systems *already in place in the public sector*. The trainings thus reinforced competencies of existing FP trainer-supervisors at central and district levels. IRH adapted capacity building strategies, materials, and curricula accordingly.

Training Service Providers and Supervisors

Service Providers. By 2007, SDM had been introduced in two-thirds of Rwanda, but the constant mobility of MoH health workers meant that refresher trainings were required. Early in the scale-up

¹⁹Both these entities are also resource organizations. Likewise, AFR and ARBEF are both user and resource organizations, and the latter maintains a handful of clinics in Rwanda that offer a full range of FP methods. This report, however, focuses on the MoH and MoH/church health facilities.

phase, IRH spearheaded a series of FP refresher trainings around the country, which included a focus on SDM as a new method. USAID-supported project staff conducted the trainings in their operational zones, with technical support from IRH. Trainees were FP providers in health facilities and CHWs, and also included technical staff from NGOs and INGOS working in FP.

In the six UNFPA-supported districts that had not received SDM training during the introductory phase, the MoH and IRH trained MoH trainers in eight-hour sessions that covered FP as a whole; subsequently, these individuals led the training of providers in a cascade approach. To work within the MoH-defined training parameters, IRH revised the SDM module from one day’s duration to 1.5 hours, with technical support from IRH-Washington, D.C.

Other organizations, such as the FBOs Caritas and AFR, also learned to provide trainings, which differed somewhat in length but adhered to national standards.

Over time, IRH’s training role diminished as Resource Organizations gained capacity to train trainers and providers. However, IRH played a lead role when the MoH began to pilot community-based provision (CBP) of FP, including SDM, in 2010. IRH contributed to curricula development (offering IRH’s CHW Toolkit as a guide for adaptation) and training plans, and seconded staff to training teams. The CBP pilot took place in three districts and began with a training of trainers, followed by cascade training of CBP agents.

Supervisors and Quality Assurance. Quality assurance was essential to scale-up, and the 2009 simulated client study (part of IRH’s baseline assessment) detected ongoing provider bias against SDM. Supervision was therefore a crucial element of the scale-up phase. In Rwanda, MoH District Supervisors make general FP supervision visits to health facilities on a regular basis, and IRH worked with the MCH Task Force to improve this supervision. For example, IRH used the results of its facility assessment (a component of the 2009 baseline)

**Box 1: Key Results of KIT Data, 2008-2012
(n=127)**

- Providers almost uniformly understood how to use CycleBeads. The mean score was 0.958 on a scale comprising seven questions, which ranged 0-1, where 1 denoted complete knowledge.
- About two thirds of providers appropriately stated each of the two eligibility criteria (periods about once a month (72%) and ability to avoid unprotected intercourse on the fertile days (64%))
- 91% of providers knew what the woman should do if she has a cycle shorter than 26 days.

to write a brief for the MoH on the state of FP services and SDM scale-up. This brief was shared widely with district officials, FP TWG members, and others to raise awareness and serve as the basis for quality improvement plans for the FP program as a whole.

One quality assurance /supervision tool that IRH used extensively was the KIT, the checklist that ensured providers know and use all key SDM counseling points. IRH used the KIT strategically, in collaboration with the MoH, in each district and at Caritas sites. IRH also supported AFR to use the KIT semi-annually during health center and community site visits. IRH also supported SDM/FP supervision in three UNFPA supported health zones to implement KIT during site visits.

As shown in Box 1, providers in general showed high knowledge and very high competence, but some work was needed to reinforce knowledge of eligibility criteria.

IRH offered the SDM KIT to the MoH for widespread use in supervision. However, the MoH felt the KIT, with its focus on SDM, was too limited for general use. Also, MoH supervision tended to focus on quantitative indicators such as commodity availability and reporting, rather than quality of counseling.

A second quality assurance tool was used to assess quality of SDM services. The Client Follow up Tool was used by district-level FP Focal Points (see next section) in three UNFPA-supported districts. Client follow up added a new dimension to program monitoring activities, assessing how well clients used the method as a result of provider counseling. Clients were invited to health centers, and after assessing provider knowledge with the KIT, supervisors interviewed clients and completed the Client Follow up form. The interview questions focused on:

- Current use of the method
- Method satisfaction
- Verifying the band was on the correct bead
- Correct demonstration of CycleBead use
- Knowledge of Healthy Timing and Spacing of Pregnancy messages
- Husband's involvement in SDM use

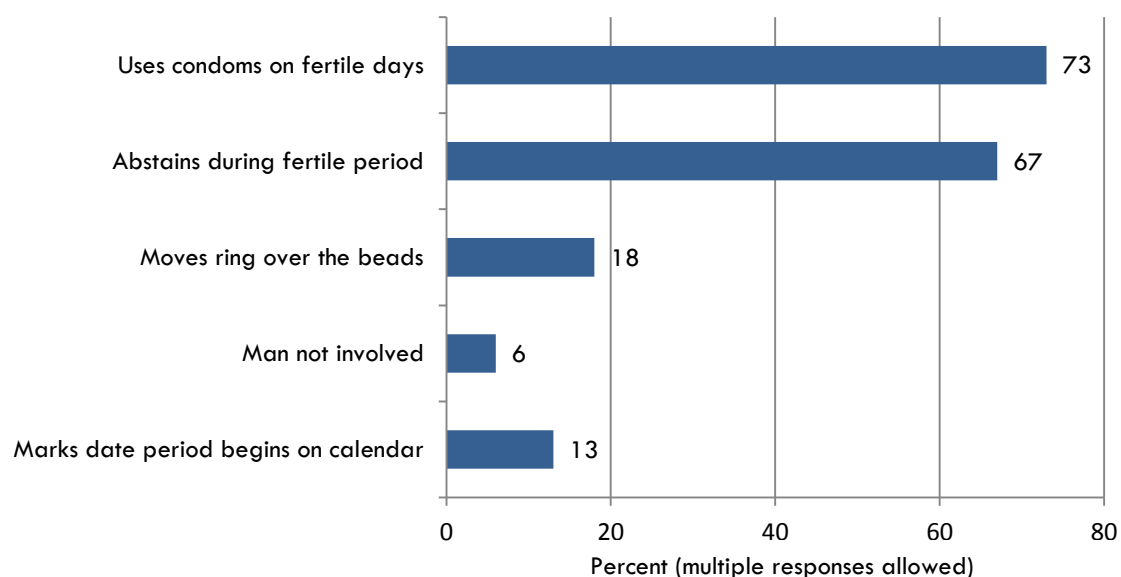
Box 2 at right shows the results of 175 client visits from 32 health facilities: overall high knowledge and correct use of, and satisfaction with, SDM. Over two-thirds of clients were aware of the importance of healthy spacing of pregnancies. Although not all women answered the question, Figure 5 below shows respondents reports regarding partner participation in SDM use (multiple responses permitted); only 6 of 87 (7 percent) were not involved in the use of SDM.

Box 2: Key Results of SDM Client Follow-Up Visits in 2011 (n=175)

- 99% currently use SDM and want to continue to use SDM
- 95 % are satisfied with the method
- 90% demonstrated correctly how to use SDM
- 72% know that it is ideal to space pregnancies by two or more years
- Almost all men participate in SDM use in some way (see Figure 5); only 7 percent play no active role

Figure 5: Partner Cooperation in SDM Use (n=87)

Source: Client follow up reports, 2012



Engaging Institutions within the Education System

During the introductory phase in Rwanda, IRH achieved most of the necessary curricula revision for pre-service training: SDM was integrated into the FP training modules used by the country's five nursing schools. In 2007, the Ministry of Education, the Kigali Health Institute, and the MoH embarked on a re-organization of nursing schools and created a single FP curriculum for pre-service training. The

Capacity Project led a team (including IRH and several professors of biology and of reproductive health) that provided technical assistance to the curriculum harmonization.

Next, IRH and others trained nursing school professors and provided support during the first year that the new curriculum was used in the classroom and in practicums. IRH then offered individualized technical assistance to the various schools in 2011. An interesting outcome of the revision process was that fertility awareness and SDM were placed at the beginning of the curriculum to help explain human fertility. This allowed a more logical progression of topics, and placed lessons on other modern FP methods within the context of reproductive health and fertility regulation.

The current pre-service curriculum includes old criterion for determining eligibility to use SDM based on cycle length. IRH's global revision to the criterion occurred after Rwanda finalized the FP curriculum for nurses. Only when another revision is scheduled will it be possible to include the new information (it is not known when this will occur). In the interim, in-service training will update service providers, since in-service curricula already include revised eligibility criteria.

Other Technical Assistance to Build Workforce Capacity

FP Focal Points strategy. One of IRH's priorities was to build technical capacity within the MoH so it could serve as its own resource organization, respond to SDM needs, and ensure SDM availability well into the future. To this end, and to expand SDM coverage to the last seven districts in Rwanda, a team of 'Focal Points' was established. Focal Points were district MoH supervisors who, during regular FP supervision, paid particular attention to SDM. They used the KIT and Client Follow Up instruments to monitor quality and collect FP user statistics. IRH provided technical support to Focal Points for six months in 2011 to build their capacity.

Another major aim of the Focal Point strategy was to reduce provider bias against SDM and to help providers grasp the benefits of including SDM in the FP method mix (for example, clients' greater understanding of human reproduction and male involvement in FP). Ultimately, as the Focal Points developed an interest in SDM and eliminated their personal biases, provider bias was reduced.

Changing IRH Staff Capacity to Support Scale-Up

During the introductory phase, IRH conducted provider trainings and directly oversaw implementation. During scale-up, in contrast, IRH trained trainers and its role shifted from implementer to provider of technical assistance to other implementing organizations. For example, trainings were no longer planned by IRH, but integrated into the training plans at the MOH.

IRH's technical staff consisted of a Country Representative and a Training Officer. The former remained constant throughout the introductory and scale-up phases; her longstanding presence and strong commitment to informed choice and quality FP services earned her a high level of legitimacy, respect, and trust from the MoH and other actors in the country. She has been extremely effective both on the political and technical levels.

Mid-way through scale-up, IRH's original Training Officer (well known as a quality FP and SDM trainer) left the project and was replaced by a former MoH employee with relatively less experience. It took time for the new Training Officer to develop her credibility with other FP actors, and this slowed the momentum of scale-up somewhat. However, staff transitions are an expected element of any project that spans a decade or so.

Dissemination, Awareness-Raising, Demand Creation

Early in the introductory phase, IRH and MoH were the primary actors in IEC for SDM, and activities largely were piggy-backed onto educational activities already underway at health centers and in communities (a few ad hoc radio shows on SDM were also done). IRH adapted global print materials

in-house to include Rwanda images and Kinyarwanda text. These were distributed by IRH and partners to facilities and districts where SDM services were being added.

How Awareness and Demand Were Created

During the scale-up phase, more actors became involved in IEC. Materials developed by the FP TWG were revised to include SDM, for example. But IRH believed that greater effort was needed outside of health facilities and within communities. It funded and worked with several partners (PSI, Urunana, Caritas, AFR, MoH) to develop demand-creation materials and media spots.

Figure 6: Creating Demand for SDM

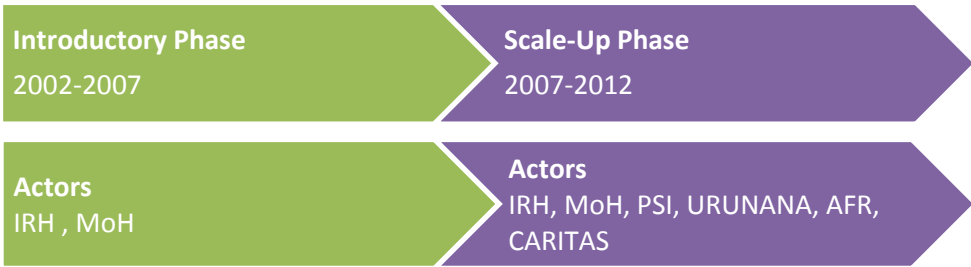


Figure 7: Strategic Shift in IEC Channels Used between Introduction (green) and Scale-up Phases (purple)



The scale-up phase saw many IEC activities, including: the use of national and even international (BBC) radio to produce and disseminate messages via spots, dramas and soap operas, and panel discussions; and of print media via published articles and newspaper reports. In 2010, as PSI began social marketing CycleBeads as a branded product (Confiance Collier), PSI and IRH developed promotional items (t-shirts, baseball hats, tote bags) and a radio spot that aired at the same time as Urunana’s soap opera. After several rounds of SDM messaging in Urunana’s edutainment program, IRH (and Urunana) assessed impact in 2012. Results indicated that the mass media approach not only addressed knowledge gaps and rumors about SDM, but led to greater awareness of men’s roles in FP and SDM use, and awareness of couple communication about FP and SDM.

To complement mass media activities, IRH added an interpersonal communication campaign at the community level. Called Each One Invites Three, the campaign used social diffusion approaches, and

encouraged satisfied FP users to give invitation cards to at least three friends who did not use FP, asking them to visit a health center or CHW to learn about and access methods. In intervention areas, 5,000 more new FP users were reported during the campaign than in the previous six months, representing a 39 percent increase in new users compared to the six months prior to the campaign. Likewise, the percent of new SDM users increased relative to SDM users in the previous six months. Three of the five pilot health zones were particularly successful (Table 6); the less positive outcomes in Rutongo and Kiziguro were likely due to the level of outreach done and the type of community association involved in the Each One Invites Three campaign. The reasons for the decrease in new FP

users in the control health zone are unclear. Each One Invites Three generated such interest that the MCH Task Force asked all Task Force members to implement it

Table 6 below shows the percent change in total new FP users during the six month campaign over previous six months by participating health zones and a comparison health zone.

Table 6: Results of “Each One Invites 3” Social Diffusion Campaign, 2012

Kibuye HZ	Mibilizi HZ	Rutongo HZ	Kilizi HZ	Kiziguro HZ	Control HZ
+ 49.3%	+ 47.9%	- 4.4%	+ 11.2%	- 1.4%	- 14.5%

This work re-emphasizes the importance of a variety of IEC channels to reach people with information and to motivate them to act on their unmet needs for FP. During scale-up of an innovation such as SDM, multi-channel IEC is crucial not only to raise awareness but to ensure that a new method is promoted to the same level that other methods are promoted by other projects—and in Rwanda, this means long-acting and permanent methods, in particular.

Constraints on Demand Creation

Constraints on demand creation were two-fold. First, IEC/BCC can be very expensive, and IRH did not have sufficient resources to develop a comprehensive communication campaign on SDM in Rwanda. Second, there was an inherent contradiction between striving to integrate SDM into the national method mix, promoting SDM individually, and promoting SDM in a MoH/donor environment that emphasized long-acting and permanent methods. IRH was a member of the FP TWG’s sub-committee on IEC, and was thus actively involved in producing IEC materials for FP overall. The disproportionate focus on long-acting and permanent methods in IEC material development was often questioned by Deliver, but in all MoH campaigns the emphasis is still on certain methods.

Advocacy for SDM Scale-Up: Successes and Failures

It would be accurate to state that, as of 2012, Rwanda has appropriated and integrated SDM. But important advocacy needs remain, in order to maintain a supportive environment and garner increased support for SDM integration from USAID and other family planning donors.

SDM’s introductory and early scale-up phases in Rwanda benefitted from a positive political environment. Policy-makers willingly and enthusiastically included SDM in the revised national FP planning norms, curricula, and other key documents.

To keep SDM integration a priority for the MoH and other stakeholders, IRH engaged in advocacy with policymakers and program managers (in addition to remaining active on various MoH committees). While the IEC activities described above targeted consumers, IRH perceived a parallel need to reach decision-makers and program managers with information about the effectiveness, appropriateness, and advantages of SDM as a modern FP method. IRH used various channels to this end: a presentation to the Senior Management Team of the MoH, one-on-one meetings with key MoH decision-makers who identified as ‘neutral’ or ‘opposed’ to SDM, articles on SDM in MoH publications and on the MoH website, and an IRH-sponsored research/policy brief. To reach MoH and other influential physicians, IRH wrote and published an article in the 2009 Rwanda WHO Bulletin that made the case for SDM as a long-term method.

IRH staff in Rwanda maintained a commitment to participate in promotional events, such as international meetings and exhibitions, to show MoH, USAID and partners the progress made (and to be made). This commitment greatly contributed to SDM integration.

IRH took care to position itself as an advocate for informed choice for FP and not merely an advocate for SDM. For example, it avoided using the phrase ‘SDM scale-up,’ because its aim was not merely to institutionalize and expand the availability of that single method. Rather, SDM scale-up was an end in itself, but—importantly—a means to the end of an improved FP program overall. With the Catholic Church, too, IRH took care not to promote SDM alone, lest it reinforce misperceptions that SDM was a method only of interest to FBOs.

Still, SDM faced some political setbacks during scale-up. For example, the MoH and FP donors’ stated prioritization of long-acting and permanent methods meant fewer resources directed towards sustainable SDM integration. The PBF system included SDM in 2009, but removed it in 2010 and 2011; in other words, health facilities had financial incentive to offer most FP methods, but not SDM.

Champions. Champions are those individuals whose support and advocacy for SDM—within their own organizations, with MoH, or with the public—exceeds the parameters of their jobs and exhibits a personal commitment to the method and/or to SDM scale-up as a catalyst for quality FP policy and service delivery as a whole. In Rwanda, the individuals noted at right were both champions and partners in scale-up implementation. Their dual roles, and their positions as respected family planning technicians, may contribute to the sustainability of SDM services after IRH’s formal efforts end.

Table 7: Champions of SDM Scale-up in Rwanda

MoH	Drs. Anicet Nzabonimpa, Thomas Nsengiyumva, Herman Habarugira
PRIME II, now UNFPA	Daphrose Nyirasafari
IntraHealth	Susana Mukakabanda
Deliver	Jovith Ndahinyuka
IRH, now FHI	Anastase Nzeyimana

Monitoring SDM Scale-up

Rwanda had the advantage of being an IRH impact study country, and the three-year SDM impact study completed in 2005 served as part of the baseline for the scale-up phase. Even before the formal scale-up phase began, IRH staff had a good understanding of the environment, service issues such as provider bias, and collaborative working relations with the MoH at central and district levels. IRH was assured of its strategic scale-up choices given this base of existing evidence. Based on issues identified by this evidence, IRH added a simulated client study to its baseline to explore provider bias in greater detail. The pre-baseline information also led to development of the Focal Point strategy described in this report.

Each year IRH reviewed the benchmarks (Table 3) in conjunction with the ExpandNet Model, to assess changes and re-focus strategies and programming for the upcoming year. When benchmark data revealed technical problems in implementation, IRH brought the matter to its colleagues in the FP TWG to jointly pinpoint issues and identify solutions. As noted throughout this report, IRH used M&E data to inform programmatic decisions in other ways: monitoring SDM uptake by district, combining training and stock out data to understand when SDM was really available, and evaluating specific activities such as demand creation to understand their contribution to scale-up.

Regular collection of service data was done, but in the absence of an IRH M&E Officer dedicated to monitoring scale-up, it was often challenging to exploit the data to guide scale-up decisions in a timely way. IRH staff in Rwanda relied on M&E staff in Washington, D.C., and on consultants to enter, clean, and analyze data.

With the entry of Caritas as a scale-up partner, data collection became more complicated. Caritas had its own reporting system, which was a source of user data useful to IRH to monitor scale-up. As Caritas began to report to the MoH, it became impossible to ascertain if the growing number of new users

reported by Caritas was duplicative of MoH user statistics. Monitoring the expansion of SDM availability and users through Caritas networks was thus compromised.

Resource Mobilization

IRH relied on USAID core funds for scale-up after USAID field support funds (\$50,000 per year from 2007-2008) ended. As noted above, USAID continued to purchase CycleBeads for Rwanda.

Leveraging resources through USAID-funded and other projects – that is, estimating expenses of projects that, for example, offered SDM services, or costs of news broadcasts and radio spots, independent of IRH technical or financial support – was an IRH monitoring objective, because leveraging is a proxy for other organizations assuming ownership of scale-up. Between September 2009 and December 2012 an estimated \$1,799,000 was leveraged, with significant amounts of television and radio diffusion of SDM messages by journalists and others, always a high-ticket item, contributing to the estimated amount. In terms of future resource mobilization, IRH and partners successfully included SDM in government commodity procurement tables, as of 2010.

Conclusions

Key Elements Facilitating SDM Scale-Up

Establishing and maintaining strategic partnerships. IRH is a small organization that worked through partnerships to have a large effect. The strong support of USAID was very useful in cementing these partnerships. In the late introductory phase, USAID staff made public and private comments about IRH such as, ‘you should work with IRH, it is a high-performing NGO,’ and this helped create necessary partnerships to move scale-up efforts forward.

MoH structure, coordination role, and support

During the introductory phase, the MCH Task Force (called the Division of Reproductive Health at that time) played a vital role in coordinating FP efforts. It held inter-organizational meetings each quarter, which created accountabilities for FP and allowed partners to learn of each other’s activities. In effect, these actors were able to witness the SDM rollout process and become increasingly engaged.

Sharing evidence to build commitment

IRH studies played an important role in ensuring scale-up commitment from partners. For example, the Service Provision Assessment (2008) found evidence of gaps in SDM services availability: providers were trained, but CycleBeads stock outs in a significant number of sites meant services were effectively not available. With this evidence, the DELIVER project took action to resolve the problem. One year later, scale-up partners were reassured by IRH’s baseline assessment, which showed that stock outs had been effectively resolved and confirmed the potential contribution of SDM to FP services.

IRH’s position as FP champion

IRH worked to earn and maintain a reputation of technical excellence, but insisted on doing so as an advocate of quality FP services overall, and not as the champion of a single method. IRH led sub-committees of the MCH Task Force, participated in training and other technical events, and undertook activities that positioned it as committed to the complete FP agenda in Rwanda. In 2010, the MoH began asking IRH to build FP capacity at district level, proof that the Institute was not viewed as an SDM-only player. As an aside, an important factor in establishing credentials was where IRH was based. Initially, IRH sub-let office space from IntraHealth, and health actors in Rwanda often conflated the two organizations. IRH leased independent office space in 2005, and its status as an independent entity was further reinforced when the MoH asked that it register with the government as an INGO—not just as a USAID project—in 2010.

IRH as bridge-builder between FBO and MoH FP services

IRH's work opened a collaborative space for MoH and Caritas—one that barely existed prior to the scale-up phrase. Caritas and the MoH used this space to agree on how Caritas would report FP users to the MoH MIS, and that Caritas could access SDM and other FP commodities for its sites. This collaboration opened the path to reach 30 percent of health facilities in Rwanda, a significant horizontal scale-up opportunity that had not existed before.

Seizing opportunities

Because it was on the MCH Task Force and FP TWG, IRH could join multi-organizational efforts to revise normative documents and guidelines, and be involved in new FP initiatives such as the CBP pilot. At the same time, IRH's proximity to MoH staff who were involved in vertical systems where SDM needed to be integrated meant the institute had opportunity to foster dialog and gather experiential evidence through field visits. As the PBF was being piloted, IRH accompanied PBF staff to field sites where SDM had been integrated into services; this helped convince them of SDM's role in FP (and eventually—albeit temporarily—in the PBF report form).

Lessons Learned on Horizontal Scale-Up

Demand creation is crucial, and is tightly linked to both horizontal (geographic expansion) and vertical (institutionalization) scale-up efforts. Demand creation activities began later than other efforts in Rwanda (a lesson learned for the future), and needed to be coordinated with actions along both axes. Given that demand creation is not a dynamic MOH role, and is left to NGOs and media groups supported with resources from the INGO community, IRH invested its resources in media NGOs such as URUNANA, and complementary community mobilization efforts with other NGO partners.

It is important to have a diverse range of user organization partners to provide leveraged entry and resources to support an expansion of services. IRH partnered with the MoH, FBOs, NGOs, and INGOs to achieve integration, which allowed both breadth and depth of scale-up.

Lessons Learned on Vertical Scale-Up

Evidence is effective in confronting common misbeliefs about scale-up and skepticism about modern, natural FP methods. IRH used a variety of sources to deal with misperceptions, including evidence from published articles and experience from field visits.

It is necessary to simply an innovation in order to integrate it into existing programs. While this seems evident in retrospect, it was a lesson well learned: Distilling the absolutely essential information about SDM, and being ready to engage in opportunities for integration as they arose (for example, when the MoH decided to revise training curricula) were key factors in achieving vertical scale-up.

Transition Activities for SDM Integration and Sustainability

Significant progress was made across the various components of scaling up SDM at the national level. The changing environment in Rwanda will admittedly influence SDM scale-up efforts in the future. Nevertheless, to assure that these achievements continue to be sustained and/or advanced, IRH identified key actors and strategies to move SDM forward in terms of advocacy, capacity building, logistics and procurement, IEC, and HMIS and M&E. Table 8 below outlines sustainability strategies for SDM scale-up in Rwanda.

Table 8: Strategies for Sustainability of SDM in Rwanda

Scale-Up Component	Action for Sustainability	Responsible Party
Advocacy	<ul style="list-style-type: none"> • Advocate for re-insertion of SDM into the PBF system. • Lobby PSI (once it transitions to a Rwandan social marketing NGO) to include CB in their product line. • Advocate for Catholic FBOs providing SDM services outside of health facilities (e.g. Action Familiale) to have access to CB. • Advocate to FBOs to report their FP statistics to district MOH. 	<p>USAID, MOH MCH Task Force and Community Health Desk, and MSH USAID</p> <p>USAID and MCH Task Force</p> <p>MOH FP Technical Working Group</p>
Capacity Building	<ul style="list-style-type: none"> • Maintain SDM in national FP training materials and activities for facility and community level providers of FP. • Ensure SDM is part of FP activities in new bilateral projects (e.g. Chemonics Project Family Health Project). Existing staff have capacity already. 	<p>MOH FP Technical Working Group</p> <p>USAID</p>
Logistics and Procurement	<ul style="list-style-type: none"> • Continue CB procurement for the public sector. • Procure and supply CBs for use in private sector social marketing, including funding for promotion • Continue including CB in their product line. • Access MOH condoms and replace inserts that include condom language with their own. 	<p>USAID</p> <p>USAID</p> <p>PSI</p> <p>FBOs</p>
IEC	<ul style="list-style-type: none"> • Monitor SDM inclusion in new FP materials that are developed by the MOH or FP projects. 	MOH FP Task Force
HMIS/ Monitoring & Evaluation	<ul style="list-style-type: none"> • Systematically report FP statistics to district MOH to include in FP user statistics. 	Caritas & Action Familiale

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